HIT Policy Committee
Draft Transcript
May 2, 2012

Presentation

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

Thank you very much. Good morning, and I'd like to welcome you the the 35th meeting of the HIT Policy Committee. This is Mary Jo Deering in the Office of the National Coordinator for Health IT. This is a public meeting and there will be an opportunity for public comment at the end. I would ask the members to identify themselves when they're speaking for the transcripts and for those on the phone. I'll begin by taking the roll. Farzad Mostashari?

Farzad Mostashari – Office of the National Coordinator– National Coordinator for Health Information Technology

Here.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

Paul Tang?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Here.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

Madhulika Agarwal? David Bates?

David Bates – Brigham and Women's Hospital – Senior Vice President for Quality and Safety

Here.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

Christine Bechtel? Neil Calman?

Neil Calman – Institute for Family Health – President & Cofounder

Here.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

Richard Chapman?

Larry Wolf - Kindred Healthcare - Health IT Strategist

Larry Wolf for Rick Chapman.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

Patrick Conway?

Kate Goodrich – Centers for Medicare & Medicaid Services

Kate Goodrich for Patrick Conway.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

Art Davidson? Connie White Delaney?

Connie White Delaney – University of Minnesota School of Nursing – Dean

Here.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor
Paul Egerman?

Paul Egerman – Software Entrepreneur
Here.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor
Judy Faulkner?

Judy Faulkner – Epic Systems – Founder
Here.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor
Tom Grieg? Gayle Harrell? Charles Kennedy? David Lansky?

David Lansky – Pacific Business Group on Health – President & CEO
Here.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor
Deven McGraw?

Deven McGraw – Center for Democracy & Technology – Director
Here.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor
Frank Nemec? Marc Probst? Josh Sharfstein?

David Sharp – Maryland Health Care Commission
David Sharp for Josh Sharfstein.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor
Latanya Sweeney? Rob Tagalicod? Scott White?

Scott White – 1199 SEIU – Assistant Director & Technology Project Director
Here.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor
Thank you very much and back to you Farzad and Paul.

Farzad Mostashari – Office of the National Coordinator– National Coordinator for Health Information Technology
Thank you. We are going to be discussing today a lot about the issue of the day, providing the comments on the Meaningful Use and sort of NPRM standards of Stage II; deadline for comment's May 7th. Pressure's building, but we thought that the community at large and this committee in particular wouldn't really want to have nothing to be reviewing after May 7th. So in the spirit of the office of no Christmas, the office of no summer, this is going to be the office of no May, and we're going to let out, what some in the Standards Committee derived as that unicorn, the governance or conditions for exchange, a request for information, for your reading and perusing and commenting pleasure. Deven McGraw is very excited, let the record reflect. And so you're going to be seeing that soon so that after the May 7th comments are submitted to CMS and ONC on our respective rules there'll be more discussion to be had.

We do really see these as being integrally related to our major push in Stage II for increased standards based interoperability and exchange. We recognize that having those standards and the Meaningful Use requirements are of meaningful use and electronic health record is really a critical building block for interoperability and exchange, but it is not sufficient. It is necessary but not sufficient, and in particular

the issues of what the conditions are, the privacy protections, the technical interoperability conditions, as well as some of the services that are going to be needed for exchange to really take off are still issues that need to be addressed. We have included in Meaningful Use a proposal, for example around the exchange requirements, that one may use a certified electronic health record and the standards therein to exchange information to meet the needs of this requirement or the Nationwide Health information Network or an organization that's been validated to be a member of the Nationwide Health Information Network.

The question that arises is, well, what might be some of the criteria for service providers; health information service providers or data intermediaries? It could be a wide range of organizations who might want to be designated as validated entities for the Nationwide Health Information Network. What might be the conditions of trusted exchange that would enable that trust to emerge? We've talked a lot about once you reduce the cost of information exchange through standards, once you increase the value through a lot of the payment and deliver forms that are happening information can start to flow at the speed of trust.

If we are to move beyond what Tim Cromwell at the VA calls the first name basis information exchange, which is that we trust people who we know on a first name basis to exchange information with, if we want to move beyond that we really need rules of the road that can enable that trust to emerge more broadly and to scale more readily than point-to-point negotiation. And one person, at least, mentioned the high-cost of legal advice to negotiate all of those point-to-point agreements between entities in terms of what's going to be done with the data, how is the data going to be treated, how is it going to be held, what the conditions are in which it is to be held.

I just want to give you a brief overview as you read the—you and all those listening will have an opportunity to read this Request for Information. We are coming out with a Request for Information prior to a Notice of Proposed Rulemaking because we do think that there are sufficient areas of ambiguity and questions. That we really want to get the broadest possible feedback prior to rulemaking, and this is going to be done through a Request for Information.

Broadly speaking the Request for Information proposes a voluntary program where organizations—and it could be a broad list of eligible organizations that we're thinking; electronic health record developer might want to choose to become nationally validated entities. There could be integrated delivery networks who might want to choose to become nationally validated under the regional or state or local or even specialty based health information exchanges, health information service providers, even state and federal agencies might choose to become nationally validated entities, and that designation is a voluntary designation. It's essentially a brand and we're separating initially the conditions for what the conditions are for meeting that brand from what might be the policy levers that might then be attached to that brand. You can think of it as kind of Energy Star label, and then, the use of that Energy Star label in a utility rebate program. In this rule we're discussing this proposed regulation. We would be discussing the former. What are the conditions? How do you get the Energy Star label, as it were? What are the conditions that would need to be met for that?

We also recognize that in the absence of national guidance, states and indeed other private sector consortia are already beginning to develop unique and potentially conflicting governance approaches to electronic health information exchange. We've heard a lot about how that could setup potentially duplication, different rules of the road that differ slightly creating a huge burden for groups. We've actually heard from states that they would welcome federal guidance on what might be some of those reasonable rules of the road.

We also believe that this can enable really a competitive market for electronic health information exchange to emerge, and make it more efficient for these entities to enable the exchange of electronic health information while protecting patients' privacy and security of the information. And really to lay the foundation necessary to support future stages of Meaningful Use. It also creates an alternate mechanism to update and to keep the interoperability specifications evergreen and to create another mechanism other than simply the biannual certification criteria for electronic health records to recognize and deem and develop interoperability standards.

In addition to the standards, obviously we talked about the Nationwide Health Information Network of being the standards, the services, and the policy as an enabled trusted exchange. Clearly, there's a piece around the conditions that relate to the technical standards for what those conditions are to be met focusing on implementation specification and interoperability. There are policies around privacy and security, around safeguards focusing on the protection of individually identifiable health information, around confidentiality, around integrity, around availability. And then, there are also business practice conditions of trusted exchange that focus on the operational and financial practices that nationally validated entities would need to adhere to in support of that trusted electronic health information exchange to enable positive network effects to develop.

We also see this as an opportunity on the services side. We recognize that in order for scalable information exchange to really take off there need to be policies around directors, open phonebooks, for identifying the organizational entities and points, and this is a mechanism of creating that. Not a single national phonebook but we're asking for comment on any nationally validated entity providing an open phonebook essentially of their endpoints that they provide services to as well as an interoperable approach to managing security certificates across the different sites so that we don't have to have self-issued certificates or, again, negotiations around which certificates you accept and you don't.

We feel that in aggregate these conditions that cover the policies, the services, the standards, the business practices will form the basis for governance of the Nationwide Health Information Network, and really enable the same kind of dramatic increase that we've seen around adoption to take place around information exchange and interoperability. We see this as really tightly linked to what we're doing with Meaningful Use and the certification criteria of electronic health records.

Happy reading and we're going to really look forward to discussions and conversations in probably several of the Policy Committee and Standards Committee workgroups. I think there are pieces of this that the Privacy Security and Tiger Team will want to look at, pieces that the Standards Committee, and the HIT Empower Team will want to look at, the IE workgroup around the business practices. I think that once we get this we'll want to have follow up maybe work together to identify some—breaking this apart and then having the Governance workgroup also meet to kind of provide us with the best information that a national coordinator could ever ask for. Thank you.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Thank you, Farzad, and actually we are looking forward to it. Deven … joys is widely felt because, as you pointed out, this is something where we're all reinventing the wheel and they're not coordinated, and so what better way than to have a federally, at least, overseeing approach. Thank you and we look forward to working with you on that. True to form this has been a phenomenal group to work with truly, both the committee and all of the workgroups and volunteers, extremely hard working, extremely dedicated to the same mission that you're on. I'm very appreciative of that and I know you are as well.

That's a good opening to say what we're here for today, which is to get some official response back to the Office of the National Coordinator and CMS about the NPRMs that were released and this response is due on May 7th. As you can see, we have almost no time between now and then, so the style that we chose was championed by the HIT Standards Committee, which is really to go through line by line. You can see, at least I'm a little nervous …, but to make sure that we get something approved from the committee. It's unofficial. It doesn't stop anyone or any individual's organization from submitting separate responses. This is not about making sure that only your response gets through. We need a committee consensus to be helpful to the Office and CMS.

I wanted to recognize the many hours, … meetings and phone calls, that all the Workgroups have contributed to to come up with, it may seem like only a few short sentences but they're really well-thought out sentences and represents a lot of work and the deliberations of people trying to do the right thing in each individual area. I want to respect what's gone in to those and to defer where we can to the work that's been done by the individual Workgroups.

Now, as we go through them a lot of them, in particularly from the Meaningful Use Workgroup, we went through with you last time and really got sign off and agreement so we're not here to rehash the

discussion. We're here to summarize what you agreed to and most of the things we're going to talk about are either new discussions that have taken place since last month or areas where we've tried to incorporate the feedback we got from this group just last month. We're trying to move forward.

Now, you know our value around parsimony and so parsimony and comments are also appreciated during this session so concise comments would be very helpful. With your permission I'd like to have the ability to move us along and keep us on track because by the end of this time we need to have an approved set of comments that we're going to pass on to the Office of the National Coordinator and CMS.

W

Paul, I do have one question before we start. I know the Privacy and Security Workgroup came up with a letter to the ONC, and I know that these are in the form of … statements or recommendations. Is there going to be a formal transmission letter that will incorporate all this or are we just going to submit things basically in a grid like we have here?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Mary Jo wants to say something.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

The approach that we took with the Standards Committee, that seems to work well, is that it is this composite document which is the body of the transmittal, but there is a cover formal letter, as always, but it's just one or two paragraphs that says, "Please find attached the work of." There will not be separate letters from the individual Workgroups.

W

That's concerning. I mean, one of the things that I was concerned about with this approach is that much of the policy recommendations have a nuance that gets reflected better in text that's harder to see in a matrix as opposed to a standard, which is sometimes either a yes or a no or an HL7 blah, blah, blah. But having said that the staff worked really hard to actually carve up our letter and most of the text is in here for better or for worse, but I would recommend that the letters that each of the Workgroups develop at least be available on the website for the public.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

In fact, they probably are already are.

W

I would like to comment on that also. There was a tremendous amount of work and wordsmithing and really getting the nuance that we really felt was extremely important so I would hate to see that missed as the things are transmitted forward.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

One of the things as Farzad said when he released the NPRM back in March was that predictability was an important attribute, and one of the reasons it's fairly predictable is because deliberations of this Committee and its Workgroups have been in public. The materials have been shared in public, and they're sitting right here listening so the benefit of the discussion is not lost. That's one point of reassurance I'd like to try to make. We are trying to have a document that they can work off of in order to go through the various objectives but I don't think the spirit of the discussion or the deliberations and careful thought that went into the letters are lost.

M

Paul, I'll just comment that the text is verbatim and there weren't changes made to the text to fit it in. It really was to put it all before the committee so the committee could look at it all together, and that was just the approach in terms of efficiency standpoint for this discussion.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

As we go through it I hope … of this committee all along that we can achieve consensus as much as possible. Where we need to come to a vote just to express sort of the difference of opinion where there are major differences then we'll do that but consensus is always appreciated.

Each of the Workgroup chairs as we go line by line—they're called out in the matrix—will give a summary of discussion. It's not the elaboration of the entire discussion but just where we stand, and then, we'll immediately open it up for discussion by the whole committee. Again, we're not trying to go over what we did last month but really look at the changes.

If that's acceptable then I want to review the minutes, which were very comprehensive, and you can see, again, even the discussion is well documented in our minutes and available both to the public as well as to HHS. Having reviewed the minutes are there any motions to approve?

M

Inaudible.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And second? Any further discussion? I did send Mary Jo some misattributions. It might be really hard to transcribe these things and know who's here but I did notice people who literally weren't here being attributed so I tried to correct those. But at any rate, Judy?

Judy Faulkner – Epic Systems – Founder

(Inaudible.)

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. All in favor of the amended minutes then?

M and W

Aye.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Any opposed or abstained? Good. Thank you very much. All right. Let's begin and you should have your 40 page handout, and given that volume we're just going to have to make progress as we go. I'll start in the first category: Improve Quality, Safety, Efficiency, and Reduce Healthcare Disparities. The topic is CPOE and as you recall we did discuss this at length. We have a brief update and I jumped the gun there because we have really exciting news, continued exciting news about the participation in the Meaningful Use program and Rob Anthony, I believe, is on the phone to give us that update.

Rob Anthony - Centers for Medicare & Medicaid Services

Thanks, Paul.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Thank you. I'm sorry for missing that step.

Rob Anthony - Centers for Medicare & Medicaid Services

No. That's quite all right. I know everybody is gathered with an eye turned towards the future here. I just want to give everybody a brief update about where we are currently with the EHR Incentive Programs. I know it's been a couple of months since we've done an update for you, and I know with your full agenda you've got other things on the plate, so this will be brief.

We're going to do a deeper dive for June and maybe talk a little bit more about what we've learned and some of the barriers as well. But just to sketch a quick overview with you, if we could move to the next slide, I think when last we reported to you it was the final numbers for January. We have the final numbers for March, which were just posted last week to our website, the

www.cms.gov/EHRincentiveprograms. If you go to the Data and Reports tab you can find the download of this.

These are the latest numbers and in January we had about 15,500 providers who registered for both programs, and we had a total of about 191,000 providers registered. As of March we have 225, almost 226,000 total with 14,000 in March alone, so we are still continuing at a very good pace with registration. We've got over 148,000 Medicare eligible professionals registered, which is about almost 40% of all of the Medicare EPs who can participate. The Medicaid figure, as we know, as we've discussed before, reaching that denominator because it fluctuates it's a little hard to get an exact percentage on that.

There are about 3,500 hospitals registered for the program at this point, which is about three-fifths of all of the potential hospitals that can participate in the program. If we move to the next slide, normally I sketch out a little bit more about Medicare and Medicaid but in the interest of time I'm just going to give you sort of the overview of what we see. When last we spoke we had made about $2.3 billion in incentive payments. As of the end of January we're now at nearly double that with almost $4.5 billion in payments in March.

Medicare paid almost $340 million in March alone to about 8,700 providers; out of those 8,700 providers about 115 hospitals. Medicaid paid over $250 million in AIU payments, the first year adopt, implement, upgrade payments, to about 5,300 providers, and in this report is reflected about $13 million in actual Medicaid Meaningful Use payments. It's to a fairly small cohort at this point; it's ten eligible professionals and 21 hospitals but we have started to see some of the Medicaid Meaningful Use payments happening.

So all combined in March we had about $603 million in incentive payments we paid through both programs. We paid a similar amount, about $600 million, in February. In January it was slightly higher at $700 million but we're seeing roughly similar levels as we are continuing to payout for the 2011 year.

As we're getting to the tail end of all of the folks that we've paid, I think we're sort of looking at where we are one year later, and I wanted to take a moment to sum up. Again, we'll go into a little bit of a deeper dive when next we talk about this, but at this point in time, over 40% of all hospitals that are eligible for the Medicare and Medicaid EHR incentive programs have received and EHR incentive payment for either Meaningful Use or for adopting, implementing, upgrading. There are hospitals that have actually made financial commitments to putting an EHR in place. We have broad level of participation on the hospital front. We do have one out of every nine Medicare EPs are meaningful users of EHRs already, and interestingly enough we have more than half of the Medicare EPs that are receiving incentives for Meaningful Use are actually specialists. We often hear that we're geared a little bit more towards primary care but we have a lot of people who are not primary care who are participating and are meaningful users of EHRS.

I want to thank our colleagues at ONC for pulling together this information for us. We wanted to also talk a little bit about where we were a year later with regional extension centers. I know that ONC is playing, again, on doing a deep dive of this at the June meeting, but just to give you a snapshot of where we are working on that end. Over 40% of all the primary care physicians in the country are now enrolled in a regional extension center. On the small practice side they're working with 50,000 providers in practices with less than ten providers and another 17,000 providers that had been in a small practice and transitioned to something larger for a variety of reasons. Out of those 67,000 small practice providers that they are working with more than half, 58% have already implemented an EHR system. They aren't necessarily to the point of having attested to Meaningful Use but they've implemented that EHR system, they've made that commitment, and we've seeing them move towards Meaningful Use.

We have similar good news on the rural provider front. RECs are working with over 70% of the small practice providers in rural areas. Really when we look at small practices and rural providers this is really what RECs were set up to do. One of their major goals was to help those providers along and you can see that they're capturing a lot of people there. In some areas like Nebraska over 90% of small practice providers are working with an REC and moving towards Meaningful Use. Similarly on the hospital front, RECs are working with about 963 critical access hospitals and another 85 rural hospitals. These are small hospitals that have 25 beds or less, and that's approximately three quarters, 74% of all the critical

access hospitals that are eligible to participate in the program, so again, concentrating resources on the areas that most need it.

This is just a sneak peek into next month. I don't have final figures because it is only May 2, but the progress continues at pace. We did begin making partial payments in this month. Partial payments are for eligible professionals on the Medicare side who have not reached the maximum in allowed charges to maximize their incentive payment. We hold that until the end of the year so that we can maximize the amount of EHR incentive dollars that we can get to Medicare EPs. We've reach the end of the filing period for those, and we are now making partial payments. You're going to see on the Medicare side is a combination of full and partial payments. About 13,000 providers were paid this month; 8,000 of those are partial payments, 5,000 are full payments. These are all unique providers so there's no overlap in between those. All together that will bring us to around 57,000 Medicare EPs that have received an EHR incentive payment.

We also started paying the health professional shortage area bonuses. That's a 10% bonus on the Medicare side that EPs who were practicing in an HPSA area can receive through the program. There is overlap. Those are not new providers so we haven't double counted them in the total number below, but we've made about 4,200 of those payments this month. Another 4,500 Medicaid EPs were paid and 280 Medicaid/Medicare hospitals were paid. There is a little bit of overlap there and it brings us overall to a unique number of about 2,200 hospitals that will have received the payments as of the end of last month. All together in the month of April alone close to 18,000 providers paid, and we are closing in on 100,000 providers who have received an EHR incentive payment under the Medicare and Medicaid programs.

We continue to have good figures, as I said. In February and March we saw about $600 million in incentive dollars get paid out to providers. This is both EPs and hospitals. We estimate that we're going to be somewhere pretty close to that for April, about $586 million. You can see that I've broken out about $7 million in the HPSA bonus payments here, and you can see that there are the full and partial payments combined for $150 million. They're at about $60 million in partial payments and about $90 million in full incentive payments; those are combined on that line.

That is going to get us in April to over $5 billion in EHR incentive payments paid for first year participation, and we are not quite done yet. There are going to be more payments that will be made in the following month, and there are payments to Medicare Advantage organization that will come as well. When we finally are able to close out and do a recap of 2011 I think we're going to see some pretty broad participation, and some good outflow of EHR incentive dollars to providers. I do want to stress that these are draft estimates for April. We'll be publishing some final reports, again, in that data and report section on our website, and we'll let everybody know when those finally come out.

I won't go through attestation data here because you obviously have to move on to other things, but I just will go into a deeper dive. I just want to give you a snapshot. On the Medicare side, we've got almost 63,000 EPs that have attested. The vast majority of them have been successful. We often get questions about successful and unsuccessful. There have only been about 285 EPs who have attested and been rejected. They were unable to meet whatever of the Meaningful Use objectives. Out of those 285; 159 EPs resubmitted data successfully. Either they had made a mistake in the data that they originally entered or they chose a different reporting period and re-entered data and were successful. The vast majority of people that we have on our system have been successful. On the hospital side we've got about 1,200 hospitals that have successfully attested to Meaningful Use. Just a reminder, all of this attestation data is Medicare right now. All of the hospitals have been successful, so there have been no rejected hospitals for Meaningful Use. All 1,200 were successful in meeting those thresholds.

Again, nothing new and part of the reason why we probably don't need to go over this, but we're continuing to see very high scores, all of the thresholds are greatly exceeded. As always, there are people who were close to the borderline within that mix, but on average we are seeing people scoring far and above what those thresholds are for objectives. There's not much difference between eligible professionals and hospitals; both continue to score very high. There's not a great deal of difference in specialty performance, although obviously, as we've discussed before, there are some differences in which menu objectives they select, what exclusions they take based on workflow.

And then, my next and final slide; this is just a quick overview. None of this has really changed from before. We're continuing to see Drug Formulas, Immunization Registries, and Patient Lists as the most popular EP menu objectives. Advance Directives, Drug Formulary, and Clinical Lab Test Results are the most popular for hospitals. The Transition of Care Summaries and Patient Reminders continue to be something of a stumbling block; they're the least popular selection for menu objectives. Transition of care is also one of the least popular for hospitals. Syndromic Surveillance is another, although, as we have discussed before, a lot of that has to do with the availability of Syndromic Surveillance database.

Essentially, we're not seeing a great change in the previous attestation trends as we close in on the end of the 2011 data. Hopefully, we'll be able to do a little bit of a recap for you in June, but overall I think very good news about where we are with the program, and continued participation in the folks that we are reaching. Thank you very much to everybody for making time, and we look forward to your comments.

Farzad Mostashari – Office of the National Coordinator– National Coordinator for Health Information Technology

Thank you very much, Rob. This is Farzad. It's really remarkable for a nation as large and complex as ours. It's hard to look at these and not feel encouraged that the combination of the policies and programs and importantly affect the really hard work at the state level by hospitals, by providers, eligible professionals. These dry numbers really translate into a tremendous effort and execution, real end execution on the part of our country, and it is terrific to be able to actually see updated and monthly—I mean, Rob just showed preliminary April information. It's just fantastic to see this information openly available and used.

We do recognize—and Rob pointed out some of the efforts we're doing, for example with the extension centers, to make sure that these benefits are accruing as widely as possible, and one concern that we have is whenever there is a national program it's around disparities, making sure that smaller practices, smaller hospitals can also meet. There were recently some papers that looked at adoption. Now, unfortunately, that was survey data so it's not as … as the data that Rob is showing. It looks back at trends from 2008 to 2011, and the good new there was that there was really an increasing trend among all groups, and a dramatically increasing trend with large hospitals and small, to take an example, increasing their rates of adoption; large hospitals going from 19% meeting the basic definition with clinic notes, which is not part of Meaningful Use. It goes … includes that going from 19% to 43% in three years, remarkable progress, and small hospitals, which in 2008 almost 6% met that test, it's more than tripled to 21%, but it's still 21% and so I would say good progress made but more work needs to be done to make sure that we continue to focus on those who are and help make successful all ranges of providers; eligible professionals and hospitals. So great, I think, progress but more work to be done.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

REC cards, this was a ten minute agenda item so ten second comments from Judy.

Judy Faulkner – Epic Systems – Founder

… help us so we don't have to try to project ourselves with another column on all these it says total possible.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. So the request Rob is to understand the—what's the denominator essentially, in some of these things?

Judy Faulkner – Epic Systems – Founder

That'd be helpful.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And Gayle?

Gayle Harrell – Florida – House of Representatives

I just want to ask for next month if we get a very specific breakdown as to what those specialties are that are making great advances. Also, a little bit more breakdown—I like Judy's comment—and we'd really like to have some more time on this next month to delve into the numbers, especially the rural and inner city areas.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

In fact, that is a major agenda item for June, so we'll be going into some detail for those. Thank you. Neil, your ten seconds.

Neil Calman – Institute for Family Health – President & Cofounder

I'd like to suggest that data be published that basically talks about the people that successfully attested and identifies the systems that they're using. I know that we can't rate them but people should know by specialty which systems have been most successful. I think it would drive the vendors to help the people who buy their products attest, and I think that the public has a right to know which systems are being most successfully getting people to be able to attest for Meaningful Use.

Rob Anthony - Centers for Medicare & Medicaid Services

Paul, this is Rob; can I speak to that one?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Please Rob.

Rob Anthony - Centers for Medicare & Medicaid Services

There is actually a data file that is available on healthdata.gov that provides a cross index (de-identified of course) between those that have attested and the systems that they have used. That information is publically available and does talk about—it is limited to successful attestation so it's actually people who have achieved Meaningful Use using those. We are also putting out a public use file of some of the attestation data (again, de-identified) that we are hoping to post to our website sometime this week. That gives some of the data through at least the end of 2011 that will give a little bit more detail about ranges within particular objectives and individual performance for particular Meaningful Use objectives. I think the former we have available and the latter is coming very, very soon.

Neil Calman – Institute for Family Health – President & Cofounder

On the former will it be on ONC's website in a format that the average physician could look at and be able to see the information?

Farzad Mostashari – Office of the National Coordinator– National Coordinator for Health Information Technology

Rob, I can take that. The approach that we've taken with this, and I think with open gov in general, is rather than have ONC or the government try to create the formats and the information and the way that would be most useful to just put the data out there. We had over, I think, 1,000 downloads of that data set and it's now being used in a variety of publications and industry reports that take a look at that and analyze it … different ways for folks, instead of assuming that if the source of truth—you know, we are going to publish a table and that's going to answer everybody's needs. I hear what you're saying, Neil. My hope is that there are lots of folks out there who have the capacity and incentive to make that useful information.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think in the spirit of moving on we—all we're going to do is if we take more time now we'll just make sure that we won't—and finish all the comments on the important issues, so I'd like to suggest we move on. What's going to happen is Michelle Nelson (who you see over there) has been really wonderful at keeping

up with the Meaningful Use workgroups and all of its children, and keeping us up to date in terms of the comments. She's going to be taking notes of our comments here, and we'll incorporate them by close of business today. Since we have to get this to ONC and CMS on Monday that means by 9:00 a.m. (according to the directions I have) Friday is the close off for the comments. She'll send that around today and we have until the beginning of Friday to make comments, and then, she'll put that together in our transmittal letter.

Okay. Let's start with the first category and it has to do with CPOE, and this is something we've discussed, and we spent a lot of time on last time and there were no controversies there. We were asked to do a little bit more definitions for scribes. The comments back are basically three fold. One has to do with order types; that we're totally in agreement with expanding order types to lab and radiology. There was a question about whether we keep 60% of totally orders or 60% in each order type, and the recommendation was 60% of each order type so that one organization could not just do two with a high-degree of clients, and then, skip the third.

The second piece was denominator. The NPRM seems to count all orders which it would include paper, and so our suggestion was to use resulted types. In other words, the meds on the med list, the lab test … resulted in the EHR, and the numerator becomes those orders from CBOE.

M

We actually said if it turns out based on the public comment counting paper order is infeasible then this would be the reasonable alternative, but we didn't actually say they had to move from paper to this unless they felt it was necessary. We're not suggesting moving from paper to this. We're suggest that first of all clarify it's paper then if—because remember if you go to this other way there's also difficulties doing it and both methods have difficulties. We're merely saying if you're not going to do the paper version than here's a good alternative.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. With regard to scribes, the workgroup didn't re-discuss it after the full committee and still felt that it was a licensed professional the best ability. Since decisions supported through CPOE was one of the most important objectives of the entire EHR Center Program it was felt that life professionals should be the individuals entering in the order and getting feedback. We went on to be explicit and say this does not interfere with however people want to enter progress notes since we don't have that same feedback mechanism.

Those were the things that we talked about last time. It's a little bit further clarification on scribes. Any other comments here? I think what we'll do is we'll go sort of essentially approving each individual item, and then, we'll ask for an overall approval at the end. Judy?

Judy Faulkner – Epic Systems – Founder

I have a question on the scribes. I was wondering about that; I had that written down. I thought we just discussed it and never actually concluded. Did we actually conclude on that one? Does anybody remember? Did we, that scribes would be …?

M

Not in a full meeting.

Judy Faulkner – Epic Systems – Founder

Not in a full meeting, okay.

M

That must have been agreed upon in one of the workgroups.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, the Workgroup presented the same position last month, and there was a request for being more specific. What about scribes in progress notes, and so we're clarifying that, and are there other ways

where an individual can have it caused to be written and yet take accountability for it. That gets in the way of if you sign in. It's not as if you could sign in as a licensed professional, and then have somebody actually do the clerical test of getting the order in because that actually ….

Judy Faulkner – Epic Systems – Founder

So is there actually a vote on this, Paul? Are we representing a discussion or we're voting?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So we're approving—those were the issues that were raised, and so we're coming back after having thought about it some more and coming back with similar conclusions about being more explicit about other non-CPOE data entry. So we're at the opening for a few ….

Judy Faulkner – Epic Systems – Founder

Yeah. Okay. Was there a vote on it from …?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

No. No, nothing was voted on last time.

Judy Faulkner – Epic Systems – Founder

Because I thought there was a variety of opinions and it just ended.

W

There were and the—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Correct. We're trying to resolve that now.

Judy Faulkner – Epic Systems – Founder

Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Did you want to have a comment on that?

Judy Faulkner – Epic Systems – Founder

Well, my opinion was to let it fall where it falls, so let them decided whether in fact their physicians are more efficient or less efficient, patient care if better or not better. In some cases it may be and in some cases it may not be. That was my opinion, but I don't know whoever else is—.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Gayle?

Gayle Harrell – Florida – House of Representatives

Yes. I think if you look at the notes, if you look directly at the minutes there are comments there both by myself and by Neil on a different approach in that it ought to fall where the liability falls. It's going to be difficult to determine who the typist is. I think the liability is the issue and the licenses professional is the one who is responsible for what is happening; therefore, that's their decision, they're liable.

M

Let me just make a comment on that. I think there are two separate issues. One is the accountability and liability for the order as an official licensed activity, and the other is the ability for the EHR its contents and the decisions for it to influence the order. And so if the workgroup was influenced more by the latter in the sense of yes, there always will be and each EHR should be programmed so that only a licensed professional can close that order. But our interest was in we wanted to get the benefits of both the accessibility of information as well as the decisions for it to influence the order as written and that wouldn't happen with some other intermediaries. That's the opinion of the workgroup but just to explain that ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I may add a point of process that at the Health IT Standards Committee meeting last time we ended up spending a lot of time on some of the add ins up front, and not enough time on the items on the end, and we just have to recognize the comments are due May 7, and this is a really critical meeting. My advice to the Committee members is we could spend a lot of time debating what the debate was, and the recommendation that I have is to really focus on what the sense was of what's on the paper and to say, "Are there edits or amendments or deletions," that you would like to propose to this in the interest of making sure we can get through all the material today. Neil?

Neil Calman – Institute for Family Health – President & Cofounder

So the recommendation, which I still think is valid, is that as long as the decision support appears at the time the order is being authorized the person that actually enters the order is not really that important. If somebody's putting in a set of orders, taking a set of instructions, it's actually the physician who has to login or the licensed professional that has to login and countersign the order or sign the order, I should say, and it's that person that needs to see the decision support. I think that that's really what we're trying to say, and I think Judy's point is we don't really know what the potential downside is of basically forcing physicians to do this. There may be people who are better at entering complete sets of orders and other things, and it's really at the point where the person who's responsible signs it that the decision support should appear and remind somebody whether or not this is an appropriate order.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

David?

David Bates – Brigham and Women's Hospital – Senior Vice President for Quality and Safety – Chief, Div. Internal Medicine

I strongly disagree with that. They way that systems work is the decision support is delivered as the order is being written, and if providers are to respond to it they have to see it while it's going in. I'm fine with having scribes for other things, but if you can point us to a system that works the way you're describing then—

M

Ours does.

David Bates – Brigham and Women's Hospital – Senior Vice President for Quality and Safety – Chief, Div. Internal Medicine

Okay. I mean, I've looked at a lot of different systems. All of them deliver decision support (that I'm familiar with) at the time that you're actually entering the order.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Inaudible.

W

I totally agree with Dr. Bates. In a system that we've been using for the last two decades I actually concur that the decision support tools really happen for the ordering clinician at the time when they're doing it. I'm not sure how it would work.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I'm sorry, again, I'm having trouble with the process here. Neil, you said— do you agree with what's on the paper? If you do then the discussion—or you disagree; you would like that removed? I can't understand what the—.

Neil Calman – Institute for Family Health – President & Cofounder

What I'm saying is I think we're being overly prescriptive. As long as the decision support appears so that the person who's legally responsible sees it, whether or not somebody else actually lists a bunch of orders and pends them in order to be signed by a physician or something, shouldn't be something that we

have to get involved in. As long as the person who's responsible for the order is the— and so if somebody decides that the program system that allows scribes to enter orders or a nurse to be able to take a bag of medications and enter the list of medications for the patient it's actually at the time when somebody signs that and checks off on it that they're assuming responsibility for it. And my understanding from prior discussions—although this doesn't have anything to do with what goes on in my own shop my understanding from prior discussions is this is not an uncommon practice, and so what we're really concerned about is the decision supports appear. That nobody can bypass a decision support that doesn't have the authority to actually sign the order, and how it actually gets entered into the system is probably less important. But I don't think this is important enough for us to spend an hour on so if the majority of people are satisfied with the way it is we should move on.

M

So we're talking about the definition of entry. Does entry mean typing at the keyboard or does it mean saying yes to the order so it can be carried out? If the order can't be carried out yet then I guess it does make sense. If the order can be carried out and then later approved retroactively then that wouldn't count.

M

I think the major point of contention in the two positions is that I believe the majority including the one that we share, Neil, if an order is pended then when a physician is going to countersign that the decision support does not reappear. That's the biggest point, and I believe that's true of, like David said, all the ones that I'm familiar with, so either we would have to reprogram all of the EHRs to do that, and that might be a legitimate way, or we're not really guaranteeing that the decision support appears before the ordering provider.

M

We can state the requirement it has to be setup such that the licensed professional receives the decision support period; that's a requirement.

M

… into the order but they receive the decision support.

M

Before the order can be carried out.

Neil Calman – Institute for Family Health – President & Cofounder

Or just say it actually is true that a nurse receiving a phone call for a set of prescriptions can enter the list of prescriptions that are being refilled or whatever, but it's not until I go on and countersign them that the drug/drug interactions and other things like really happen, and so it is true that other people can enter the orders in the system. Every time a patient of ours calls for refills, you know, the nurse who's handling that actually enters the list of medications that needs to be refilled, but when I go in and sign the order which authorizes it that's then the decision support appears that says, "These two drugs interact." I think that you don't want to have to force now all of a sudden every time a prescription refill request comes in you're not saying, "No, the doctors is the one who actually has to list the medications that are being refilled." That's not a helpful move forward in the system so I think that George's wording really deals with that situation, and we shouldn't be overly prescriptive in how somebody actually lists things in a system. We want people to do the work at the top of their licenses.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

We have two implications; one is in certification criteria, and the other's actually how it is implemented, how it is customizing in an individual setting. There would have to be auditability that says, "This system is set with the functional capability in the EHR to produce the decision support for every person that comes into contact with that order." Okay. I think those are the two main—if I look at David and Dr. … so if those accommodate those then I think we're voting between the two options. One is as written, before you; and the other is modify it to say that both the systems need to be capable of and the system needs

to be configured so that decision support happens for all people who touch that order. That's the consequence of the discussion; at least as I see it. I see a lot of head nods, and measured that way.

Okay. Let's try what's on paper right now because at least it's very well-defined. It's in front of you and look for all those in favor of what's on the paper right now, and, of course, only voting members; so one, two, three, four; okay, so there are four people. Okay. So the other option is that it would be updated to say that the ordering provider needs to sign off on this in the presence of CPOE. The consequences: certification criteria needs to be updated so the EHR systems can do this; and two, that in a measurable way the healthcare organization has to have that turned on and know that for all people who touch the order have seen decision support on that particular order. Okay. In favor of that motion; one—

W

I don't understand this issue enough to vote, to be quite honest. I mean, I assume Neil's got a certified system. If he's saying that he orders it in the way that he does and still gets decision support, I frankly don't understand why we have to prescribe this down to the person, but I just don't know enough about the systems to know.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So the statement that—

W

We all agree that the decision support needs to be seen by the licensed professional; bottom line.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So the opinions of some on this committee say that the vast majority of EHRs are either not capable or not configured to do such, and that's part of the issue. Okay, so going back to the revised version, which has decision support appearing in front of all those that touch the order, so I have one, two, three, four. Okay, and then, let's—

W

Inaudible.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Is there five?

W

Inaudible.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I mean, you're allowed to abstain. I mean, you're allowed to stand ….

W

Then I'll abstain but, again, I'm feeling very uncomfortable of the yes/no aspect of this because I feel like there is a lot of sort of uncertainty around some of the information about this, and what seems to be a very common thread that we all agree on and that I think we should emphasize is that the decision support needs to be seen by the licensed professional who's ultimately legally responsible for the order. How it occurs in a workflow manner seems far less important to me.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So actually both of the motions would actually accomplish that; that's one of the points.

David Bates – Brigham and Women's Hospital – Senior Vice President for Quality and Safety – Chief, Div. Internal Medicine

Yeah. I guess that I would comment that the workflow is actually pretty important. I wrote a paper called 'Ten Commandments for Effective Clinical Decision Support', which has been cited hundreds of times,

and where things appear in the workflow is, I think, number two. It's the second most important. It has a huge impact on whether or not people actually accept any of these suggestions, and the implication of delivering every piece of decision support to everybody actually, I think, would have really negative workflow implications since it would create a lot of extra work for a number of people who would not need to see it.

M

For both the negative side and it really violates the … that David wrote about. About how do you make the right seem triple easy to do? It's not by dropping in after the fact.

W

I think Deven's comment, and if you can rephrase things that the licensed entity is the one responsible and is the one that needs to see it whenever they are signing off or whenever they are doing it, is really the major thing. Not everybody needs to see it; it's the one who's responsible needs to see it. It covers what you're trying to do.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

We have to do the eye on the prize and feet on the ground, and the feet on the ground is what exists in today's systems, and we can't automatically report them all in today's systems. That's one of the struggles of ….

Neil Calman – Institute for Family Health – President & Cofounder

But feet on the ground is also what current workflows are in people's offices and how much we're expecting electronic health records to completely dismember all of those things. People come in with a piece of paper from a specialist who's about to do surgery to a primary care office and say, "I need these lab tests done and I need a chest x-ray and I need an EKG," and now that stuff is done by a nurse. They come in. The orders are written for those lab tests. The orders are written for the chest x-ray because it's required of the surgeon to do that, and now, we're going to basically say that the physician has to be called in to do that when right now that's a nursing function. I just think that if we start to put work that over the years has been channeled to other professionals back in the hands of— all of it in the hands of physicians in order so that somebody can see a decision support that may or may not even arise in a situation like that we're basically loading physicians with work that they absolutely have no requirement to do otherwise. And I think that is just a mistake in terms of the acceptability of electronic health records and the rate at which people are going to find them adopted.

Farzad Mostashari – Office of the National Coordinator– National Coordinator for Health Information Technology

Just give me one second Paul. Here's the problem; number one, this is Meaningful Use. What this whole thing was about from the beginning is decision support because that's the vision. I mean, it's giving people the data they need, and then, it's adding decision support. The danger is—and Neil you're not doing this but the danger is you have a whole bunch of people entering orders and you come along and you get a panel of 100 orders to sign off on, and are you going to read those decision supports or are you just going to sign them all hoping that the person who entered it kind of dealt with the decision support before you? And if you don't want that to happen then suddenly you have to start making rules and say, "Well, if you're going to sign off on them you have to sign off one at a time," and suddenly I'm prescribing the workflow. So that's the downside of the proposal you're saying; is that it makes— and that's basically thee workflow that David's talking about; that you can sign off on too much at once and ignore the whole thing. Paul?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I would just say in the interest of trying to move along this is still just the very first issue. I'm wondering if we could simply report that there was not a consensus on this topic and summarize the conversation. That would be useful information by itself, and then, we'd go ahead and move on to the next issue.

M

I do think it was five to four because, Scott, did you vote—?

Farzad Mostashari – Office of the National Coordinator– National Coordinator for Health Information Technology

Yeah, that could be in the summary.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So in the interest of clarity we're going to recall the vote, recount the vote. I think the discussion is circling. We do have the two issues, and so let's go through it again with all the committee members voting. Those in favor of what's written on the piece of paper in front of you? One, two, three; okay three. Those in favor of a revised version that includes the EHR having the capability of showing the information to all people who touch the order and measurably recording the fact, and the numerator would have to be those— Let me try that again. Revising the wording as George portrayed, which is that the final authority of the authorizing provider saw decision support. That has implications for certification of the EHR that they have that capability and a knowledgeable way that the functionality was turned on and implemented during the course of the reporting period. In favor of that motion; one, two, three, four, five; and then those abstaining; one, two, three. Okay. We clearly have a very split vote. Pardon me? Four. Okay. We clearly have a very split vote. We're just going to have to record sort of the pros and cons of this and give that to CMS and the Office.

Okay. Let's try to move on then. It was important. It was one of the most important issues here. Number two is fairly straightforward. The proposal from the NPRM was that we include drug/drug interaction check and drug allergy checking into clinical decision support. And the Meaningful Use workgroup agreed with that and commented that this is such an important area one because of medication errors; and two, that the current approach with the current commercial database could produce a high false positive and that has a … effect, so we want to work on this further in future stages.

Any difference of opinion with what's written here? Okay.

Next one has to do with transmitting electronic prescriptions, and the NPRM has done two things. One is increased the threshold from 40% to 55%, and then, had added the hospital discharge 10%. The Meaningful Use Workgroup felt that because of patient preference and local pharmacy capabilities that 65% may be too high and recommended 50%. Micky, you want to report on the IE Workgroup?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Yeah. I didn't see that the Meaningful Use Workgroup recommended 50%; did they? They did, okay. So we on the IE Workgroup recommend 50% as well. They're just noting both things; that there are a lot of geographic variations still and there seems to be a consistent lag in adoption of e-Prescribing capability particularly by mail order pharmacies.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. Any further discussion? Okay, so it seems like people are in agreement with the recommendation. That the recommendation, the response be instead of 65% it be 50%. Okay. The next one is the demographics. The only comment here is that the NPRM suggested that we'd be moving from 50% to 80%. The Meaningful Use Workgroup did want to get a bit more granular noting that the CDC demographic standard is more granular. It's not as granular as what was proposed by the IOM, but the IOM proposal doesn't have the accompanying standards, and the CDC demographic standards can be mapped up to the 1997 OMB standards. Any further discussion on this point? Okay, so people seem to be in agreement with that response.

Okay. The next one has to do with the up-to-date problems, meds, and allergies, and I'll just take that as a group. The point here was that the proposal was to consolidate all those into the summary of care document, and the Meaningful Use Workgroup was concerned that relegating it to the document may actually cause it to either be harder to get to or potentially the documents created automatically so you can't actually get to it. Also, one of this important coded information to be in front of the face of the

clinicians' viewing information, and more towards having more accurate and complete problems, meds, and allergies, and we are hoping to deal with that in Stage 3, and are actually working on that right now in terms of automated ways of increasing accuracy of that information, and David Bates actually has paper on the effectiveness of that. That's the rational for us sticking with those three items at a top-level objective. Any further discussion on that? We seem to be in agreement with the words here; good.

So that takes care of the next two as well. Now, we're going to vital signs and we had no further comment or disagreement with the NPRM. Any comments? Okay.

Next one was smoking status; the same, going from 50% to 80% and there was no disagreement in the Meaningful Use Workgroup. Okay.

Next one is the drug formulary checks and that got incorporated into the ERX core objective. The Meaningful Use Workgroup was in agreement, and IE workgroup?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Yeah. So we have a couple of disagreements with both the NPRM recommendation here so our overall recommendation is that this be retained as a standalone objective; de-linked from e-Prescribing because these words standalone in Stage 1 and they were consolidated as a single one. E-Prescribing and formulary were consolidated as one for Stage 2. We recommend that they be de-linked mainly for the reason that we believe the formulary checking should apply to all prescriptions not just electronic so that's the reason to de-link them.

We also had recommendations related to automated formulary checking. We recommend that be a certification requirement and that from a behavioral and Meaningful Use perspective that providers are required to use the automated formulary checking when prescribing or for any prescription whether it's paper or electronic. And then, finally that the measure itself would be that the eligible professional is enabled to turn on the automated formulary checking, and should certainly not be required to do out of workflow formulary checking given that the formularies are not sort of universally available in a user friendly format.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Any further discussion on this point? Neil?

Neil Calman – Institute for Family Health – President & Cofounder

So basically what we're asking people to do is to make sure this functionality is available but there's no threshold in terms of the percentage of medications that—

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

No because as we talked through this if it's enabled the measure would be trivial because it's just measuring what's available and …. Yes, that's right.

Neil Calman – Institute for Family Health – President & Cofounder

Right. I just wanted to clarify that because I think that's exactly the way it should be done.

W

Yeah, I agree.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

And what we didn't want overall was to allow—the reason that we focused on automated formulary checking is because there are formularies that are made available in a wide variety of other ways. As we know, you can go to websites, you can do …, but what we didn't want is really for Meaningful Use to reward insurers who don't make formularies available in a user friendly way.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, further discussion?

M

Does this mean that the private doctor has to have access to all the formularies for all the payers, for all their patients in order to meet the Meaningful Use objective? That was one thing we were worried about. What's the requirement on the doctors?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

So the EHR will be required to be certified for automated formulary checking, and then, the physician is only responsible for whatever formularies are made available in an automated way through the EHR. They're not required for 100%; it's just whatever is made available, and we think that will induce more and more formularies to be made available through user friendly electronic channels.

M

… paper prescriptions?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Yes. So even though they're not routing it electronically they're still, you know, going to be … reach out and doing the search in the EHR.

M

Maybe I do not understand what you— so how did—formulary change should apply to all prescriptions not just electronic. How would the automated formulary checker know about the non-electronic prescriptions?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Specifically for a lot of the ones that aren't electronically routed they're still entering them in the EHR so if you're doing a search a formulary check can happen in the EHR; it's just not electronically routed.

M

Oh, okay, so that could be made a little bit clearer I think.

W

We're doing it now.

M

Just for clarification, Micky, the formularies are—and this is a technical question—the formularies in order to do this there's this standard format in which they're available to providers now? If you're not going through some sort of formulary clearing house or a compiler of these things is there a standard way in which they're presented now so that an EHR would go and look through seven or eight formularies that would somehow have to be downloaded into somebody's system in order to make this work?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Well, my understanding is that SureScripts—let's take one network—does have a standard for this and a requirement, and that NCPDP does have formulary as a part of the standard available.

M

And is there a cost of an individual provider to use that system in term of—I mean, are we adding the cost for like every transaction for an individual provider to use that system?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

So again, just for SureScripts (again, speaking for one network) they don't charge but EHR vendors do charge providers for access to the network and that varies by EHR vendor. But I don't think that they charge extra for formulary checks. I think that's a part of typically what would be a part of the price but they're paying for e-Prescribing functionality generally.

M

Just one comment on this; I think this is incredibly important from a patient point of view and from a usability point of view and it's one of the largest complaints that patient have. It's that they end up going to the pharmacy for something that's more expensive than something else that could have been covered or wasn't covered at all by their insurance. My concern is just what it requires on the part of the individual providers, specifically small providers, to try to get formularies either at a cost through some clearing house or else having to figure out how to load these formularies and update the periodically from insurers that might not provide them through a single source. I just don't know. If that's not a concern then we can skip over this, but otherwise I think we need to be concerned if we're saying that you have to do this for every formulary that's made available in a particular format. That's requiring a level of technical understanding that I think most providers don't have.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

The intent was certainly to try to only make this required in ways that don't require extra workflow, so that was the intent of the automated formulary checking. The idea is that what—you know, maybe we can work in a language or something like that it should be about what is made available to them through their EHR. Right now we have one large prescribing network but there are other ways that they can get formulary in electronic ways.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I want to remind people for the benefit of the transcriptionist you need to announce your name before you talk, and this is Paul Tang. The other half of the equation is knowing the individual, the patient health plan not just in terms of for the health plan, so that's a big chunk that isn't always kept up to date.

M

Yeah but you consider that discussion—

M

That's right and so that would be part of the standard to say that it should be appropriate to the medication, the patient, the insurer, and the plan in the product group plan that they're on.

M

Which is fine but we don't always know their plan.

M

Inaudible.

M

And for some EHRs that are separate from practice management systems that information may not actually come across the electronic health record. All of the information on the specifics of the plan might be something in a registration and billing system that may not come across an interface to an electronic health record system so that's a whole new ….

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Yep, that's certainly true. So maybe there's an exclusion that's needed there or something in the way of integration requirements that I know we're going to get to later with the CHR team.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

This is Paul. Just to clarify this right now is just to turn it on and it'd be on an entire reporting period. There's no threshold or anything so that's part of how—

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Assuming the system is certified.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right. Any further discussion? Is there acceptance of the words here with some modification in terms of clarifying some of the points? Okay. Okay. The next one is advance directive. It's been before this Committee a number of times. It continues in the NRPM to be a menu option for those over 65 in the hospital side and for providers, although we had recommended that we begin with providers it was not accepted in the NPRM. Now, remember what we're talking about. Even though we did initially propose for it to have both the existence of the advance directive and if yes some pointer to how you would get that, the Meaningful Use Workgroup dropped that down to just making a start with recording whether an advanced directive exists for the EP as well. And the recommendation was for more than 10% of those 65 or older with the intent of moving it to core in Stage 3. The proposal form the HIT PC and the Meaningful Use Workgroup in response to the NRPM was one, to make the hospital requirement for the existence of an AD to be core; and two, to add a new menu item for EP. That is what is written before you; any further discussion on that? Christine?

Christine Bechtel – National Partnership for Women & Families – VP

So I think our original recommendation was also around providing some instruction on how to access it. If it does exist where can you get a copy? We had come back off of a place where we're trying to store it and retrieve it electronically. Folks thought that was a little bit too much, so I'm wondering— but I hate to lose this notion that you could get directions on how to access it because that is really important for patients and families. And I'm wondering how people would feel about adding a comment essentially to Meaningful Use Workgroup that for both EP and EH that CMS and ONC should lay the groundwork now for being able to, in Stage 3, add directions for how to access that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

An alternative is something that we had proposed and actually CMS had asked us back in the Stage 1 days was to actually have a hearing on advance directive because what they've been saying is there's a lot of complicating factors; a lot having to do with state legislation. I think we owe it to everyone to have a better understanding, and I think that's one of our plans. I think that would be accommodating you're concern.

Christine Bechtel – National Partnership for Women & Families – VP

Okay. That'd be great.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Other comments about existence of AD as a menu for EP and a core for EH? So we're in agreement with what's in the written text, okay. Back to clinical decision support, we'll try to enumerate the issues. We had gone from a Stage 1 requirement of one CDS rule, which is a type of CDS, to a more flexible approach of saying, "Alright, without describing what kind of CDS intervention that you do, do five of them that meet these criteria," and we had five criteria listed. It had a lot to do with knowing essentially where the knowledge comes from, being able to configure it so that it's delivered at the right time to the right person in a place that's efficient for the individual because otherwise it won't get done, and that's it's integrated with the EHR not a go-to separate place.

That appeared in the certification NPRM with a couple differences and let me try and point those out. One is we had talked about having just a source of citation of the basis for the decision support intervention, and there were a number of other attributes that hopefully are mentioned somewhere—I think you have to turn to detail. I can read them out if you need—that were mentioned in the NRPM for certification. And the others, there was a special call out for "linked references" and they reiterated the CDS attributes in that.

It's feeling of the Workgroup that there was no reason to call out a—I mean, the whole purpose is to become flexible and discuss CDS interventions that meet certain criteria rather than prescribing any one kind of CDS. We would recommend eliminating that call out for one of the kinds of CDS that is the link references; further discussion on this one? It sounds like we're in agreement with these points. Okay.

The next one has to do with clin lab test results, and appearing in structured form in the EHR. This is not the HIE version, just to point out. Okay. So we were in agreement with the NPRM. The question that came up at this Committee was is it okay to count individual tests? I believe both the NPRM and the feeling of the Meaningful Use Workgroup is yes, so individual test will count both in denominator and in the numerator.

W

Can I just point out that there was a mistake on the printout, so what's reposted up here is correct but what is on the paper isn't?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

You know it's a mistake, what?

W

That the EH measure wasn't included, the separate … we are on so it's not actually an objective.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes. Okay. Got it.

W

It's a … dependent measure.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay.

M

Inaudible.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Oh, restated, so as I mentioned there's an HIE kind of requirement about hospital labs sending structured results, and we're not discussing that at this point. We're going to go in to that, the next layer—

W

Just cross that off.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Just cross that off. Okay, so we're at agreement with this point then? Okay. The next one has to do with generating patient lists, and that was accepted in the NPRM. The one difference between what this Committee recommended and the NRPM is that we had suggested going to multiple specific conditions rather than just one. One of the applications of that is then you could work with disparity variables, so you could look at disparities within a specific health conditions; disparities in diabetes management for example. Not that you're prohibited from doing that but this sort of give you the ability of— If this goes into certification criteria, as it would, then you would automatically at least have that capability of working with multiple conditions when you produce your list.

W

Or multiple chronic conditions.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Exactly right. Any discussion on that point?

Christine Bechtel – National Partnership for Women & Families – VP

It's Christine. No discussion, completely agree but I just think the language needs to be a little stronger. A little bit more clear that that's what—it's sort of passive like we had suggested it but I think what we're saying is we are recommending it, yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Exactly right. We even give that example because we did point out in our discussion that disparity is just one of the things and you can't just look at disparities alone. You have to look at it with respect to some conditions. Okay. The next line—I think we're doing well—has to do with prevent— pardon me?

W

Don't jinx it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I know. I know. As it was coming out I was going I shouldn't have said that. Okay. With regard to patient reminders; basically for preventive services or follow-up reminders we basically accept that NPRM and there's a point about specialists and particularly proceduralist, surgeons. If you do a onetime procedure you may not need—anyone without ongoing continuing care may not have either preventive or follow-up outside the immediate acute situation. That's where we thought that some exclusion might apply. Discussions on this point? Okay. It looks like we're in acceptance of that.

The next one has to do with electronic medication administration records (EMARS) and this is a well-appreciated patient safety countermeasure; countermeasure meaning against the medication errors. And the Workgroup agreed and I think we discussed this last time too. Any further discussion on this? Okay.

Next one has to do with imagine. There's a new objective called out in the NPRM asking for 40% of those scans and tests whose result is an imagine to be accessible from the EHR. The other point was that there was a 10%— Let's see, I think this one should have— This one we're at 10% transmission correct, and it's just not showing up on the words here? Okay. So let's take those separately. The Meaningful Use Workgroup talked about the fact that some rural locations may not have imaging centers that have the capability of transmitting this electronically so we wouldn't want to penalize the provider. We're suggesting that 40% be dropped to something like 10%, and, again, the theory is once you have something going you're not going to stop because you hit 10% threshold. Yet there are plenty of extenuating circumstances where it may not be easy, feasible in some locations to achieve 10% of all your images.

The second question is exchanging images and a threshold was sent of 10%. It's the opinion of the Meaningful Use Workgroup that Stage two 2014 is too early to expect that amount of exchange; of 10% of your image test orders. Comments? Christine?

Christine Bechtel – National Partnership for Women & Families – VP

The scripting; I have a question I guess. To me having a 10% threshold was an exclusion if they have no access to electronic images. Why would they pick a menu item about access to electronic images if they don't have access to electronic images? Am I not getting something here?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, it's only—you know, you have to pick currently two out of four.

Christine Bechtel – National Partnership for Women & Families – VP

Two out of four menu items, right. But I guess what I'm asking is, is it possible for someone to pick this and exclude themselves from it so they don't have to do anything?

W

Yes. Yes.

Christine Bechtel – National Partnership for Women & Families – VP

Which seems to me to be not—

M

No, not any longer.

M

They fixed that. You need to have that exclusion just in case they can't do three of them, but if they can just not do two of them they're not allowed to pick it as a menu items so that's fixed in Stage 2 proposal.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So having an exclusion is an important thing to do just in case someone actually, legitimately can't do three of them. They need to be able to exclude themselves from that one.

Christine Bechtel – National Partnership for Women & Families – VP

But that doesn't prevent you from—does that in fact prove—it does prevent okay. Thank you.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

You must do two if you can do two, so you can't get a buy on this just by being excluded by that one. At least that's the proposed rule anyway.

Christine Bechtel – National Partnership for Women & Families – VP

So we definitely need to make clear we support that notion because there were some programmatic dimensions that are not going to get covered in the line-by-line functional criteria so I think we want to be really clear that we support that programmatic change.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

That's an important point. Let me finish this discussion then I think we'll pick that up separately. Neil?

Neil Calman – Institute for Family Health – President & Cofounder

Just, again, technical questions that I don't know the answer to. Are there transmission issues in relationship to transmitting images that go beyond what some people might have capabilities of doing now? Might the problem be, you know, technical slowdown if there's … and stuff? And then, the second question is about storage requirements for these images, and whether or not we're calling something out that requires additional storage to be available on the systems. I don't know whether these things get locally stored once you look at them or whether or not they're actually brought down at the time you look at them and not stored locally. I just don't know what the technical requirements might be for small providers who are doing this.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

But I think the NPRM allows—the point was just to be able to link to that patient's image for what you're looking at, the text result. It does not require local storage. With regard to your first point, availability of broadband would be an impediment, and I don't recall whether they were applying the FCC broadband availability and strength to this. Does anybody else know? Okay. That can appear in our comments.

M

There are some new technical approaches that would allow you to circumvent that but they're not widely used yet.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Paul Egerman?

Paul Egerman – Software Entrepreneur

My comment is I look at the objective where it says imaging results; I'm wondering if we're looking at this the wrong way by actually storing the image. Isn't in many cases all you need is the radiologist interpretation? I mean why store thousands of MRI images when you can just have the interpretations from the radiologist that says, "This is what it is," and isn't that a preferable approach than what is shown here? We don't really need all the images in the EHR.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

It's accommodated in our test results, the text is, but this is really to address some of the needs of specialists in particular and some of their needs for images. It does not require, as we've discussed, download and storage of the information. It does make it available very easily if … is available that you click a link and you get immediately to that information if you chose to do that.

Paul Egerman – Software Entrepreneur

How would we measure it if we're not—if we're not required to look at it, to download it, and we're not required to store it how are we going to measure the availability of that on the other end? Basically you're saying all of the images that I order for the year whether it's 10% or 40% you could do that from the order entry part of it but then, how will we ever measure what percentage of those are actually available for me to look at? I don't know if you can actually measure that. You wouldn't really know.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think you would know because you stored a link. You programmed your EHR to store a link to that outside or inside system to the imaging system.

Paul Egerman – Software Entrepreneur

Do we have a way of … links in the system and—?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Because it would appear in the record, in the result. You'd have the text result and then you'd have a link. I'm going to put ….

M

We've counted those in a number of small practices, for example.

Paul Egerman – Software Entrepreneur

So that certification requirement would be that it appears as a link attached to the result somehow and that we count how many times there's a link that's attached to—? I think, yeah. I think the other point that Paul raised is important though. I mean for some of the images that are produced or lack of the images that are produced they would be completely useless for us to look at. I mean, an MRI scan could have 80 images, you know, 80 slices of something, and all we're really looking at is the two lines of the result. So I mean, I just—I don't have any objection to leaving it the way it is; let me say that. I just think we don't want to make things that are sort of not useful.

M

So the question is— remember we were working on image for Stage 3 then this came out, so I think the 10% and the fact that we're just doing the first one not the second one is our attempt to do something in Stage 2 without making it onerous. Counting links doesn't sound that rigorous but that's okay for Stage 2. But we want to do images not just the report. We want something getting started on the image side. We already have reports.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

As Neil pointed out this is largely a certification. It's an EHR functionality point of view. It's fairly straightforward and it's reasonably common in bigger systems, and it's also a pie value to many of the specialists so we want to make it available. There's no use requirement, and I think it is fairly straightforward to count the number of links that are transmitted.

Paul Egerman – Software Entrepreneur

Does it even belong on our side or does it really belong just on the certification?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

We generate the objectives that go off the standard … certification.

Paul Egerman – Software Entrepreneur

No but I mean the measurement part; does it really belong on our side? If systems are being designed to be able to put a link in the report why do we need—?

W

If there's no criteria you can't have a ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah, it's a meaningful use.

W

… match the Meaningful Use criteria.

Paul Egerman – Software Entrepreneur

Got it.

M

Again, just to comment; if we want to have, for example, specialty or … who uses a lot of images using this as a menu item it has to be not only within the certified product but they actually have to attest that they're meeting their Meaningful Use menu options to this measure and that they can do that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And there are a lot of good uses for images that are good quality and efficiency so no question there. Judy?

Judy Faulkner – Epic Systems – Founder

Just a technology question or comment, and that is how this is being done is, I think, under a lot of change right now from the ways of accessing this, and I think we have to be very careful as we write this that we're not necessarily saying we're incorporating the image. It might be little different things we're incorporating. I'd be real careful about that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

That's the intent and I believe that's the way the NPRM was written. Other comments? Okay. So let me cover this second point then. We talked about the threshold 40 to 10% and essentially the accountable links. The second question is the NPRM asked for 10% of the images to be transmitted electronically. The feeling of the Meaningful Use Workgroup is that was premature. Our recommendation was to not include that certainly in this stage. Any discussion on that? It sounds like we're in agreement with the text that's written here. Okay.

Next one, family history. This is a new objective appearing in the NPRM. The Meaningful Use Workgroup talked about this. Clearly no one is against family history, taking a family history. There are two issues. One is not in the current systems are family history captured in any standard way; and secondly, what is the family history and how extensive is it, and is it important for every specialty and every encounter? That's where it's sort of the cost benefit value proposition arose. Those are the points from the Meaningful Use Workgroup; any comments/discussion about that? Christine?

Christine Bechtel – National Partnership for Women & Families – VP

So I know we talk about this a lot but I would say that it is a menu measure so I'm less worried about specialists and others who it may not apply to. But I keep asking this question and I note here that we don't have a response from the Standards Committee, but we keep asking to get input from them because the letter that we had from, is it OMH (I forget) basically said, "Hey, here are standards." And so we were trying to reconcile what's really the case here and it asked for Standard Committee input. Did we get that at any point? I guess I'm not quite buying that we're not aware if we don't have input from them.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

This is Mary Jo. It will take me a minute but I do have their consolidated comments, so let me go see if I can find it.

Christine Bechtel – National Partnership for Women & Families – VP

That would be terrific. Thanks.

Neil Calman – Institute for Family Health – President & Cofounder

I just think this is a critically important issue to figure out how to incorporate. I mean, there's more and more data. That as you're using decision supports to try and call out different kinds of screening methods a lot of this stuff more and more of it is now being connected to family history and other ways of assessing risk. For example, you know, there's a lot of data recently that's come out in the literature that really says that there should be very different recommendations for the performance of screening mammography based upon family history as a major factor. The age group between 40 and 49 recommendations are completely different if you have a positive family history of if you don't, and I think a lot of this cancer screening stuff is going to end up—until we can load the genetic information we're going to—family history is critically important so if there is a way of capturing this in a standard way I think we should begin that process. If not, we should figure out how to make sure that the certification people are figuring this out between now and Stage 3.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

David Bates and David Lansky.

David Bates – Brigham and Women's Hospital – Senior Vice President for Quality and Safety – Chief, Div. Internal Medicine

I agree with Neil that this is really valuable information. We're doing a lot of work on it. There are actually several different standards you can chose from, and we're using several different ones in different parts of our own network, which is a little embarrassing, but we are able to use decision support despite that. I think the way this is worded is okay, and it gives you sufficient flexibility given the menu option, but it's valuable to include it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Which is worded, the say the comments are or the NPRM?

David Bates – Brigham and Women's Hospital – Senior Vice President for Quality and Safety – Chief, Div. Internal Medicine

The NPRM, although I do share concerns that no one has agreed about what the standard is.

W

Well, we're partly ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

The …. David?

David Lansky – Pacific Business Group on Health – President & CEO

I don't agree with the last thread, people asking, and encourage that we savor the NPRM language. I think if we don't do that we'll lose on opportunity in Stage 2 to get the Certification Standards Committee and the vendors put in place, the data fields and so on, so that we have the ability to move to the next step in Stage 3.

W

I think David just made the point which is if we ask for it then that does trigger the Certification and the Standards Committee to select a more fixed set of standards.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

George?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

George Hripcsak. Would it make sense to have a quality measure that triggers because a family history if like saying we should include the physical exam. Well, it depends on what the problem is. If the family history you receive is very broad you want to ask about cancer risks. You want to ask about cardiac risks. You want to ask the most important things. Do we need to identify either what kinds of risks we're going to ask them about in the family history? Or do we want a quality measure that would use the family history as part of the calculation? Or something that steers it a little bit other than just saying everyone needs to enter family history and that could be as broad or as narrow as someone imagines.

M

Well, the important ones are breast cancer, colorectal cancer, and cardiac disease; those are the most important ones. Now, there actually are some norms about what family history you should collect from everyone. The Surgeon General has a set of recommendations, and then, there's some others which are more limited, but if we wanted to pick a few those are the ones that were the most valuable.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Mary Jo?

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

They are not recommending a standard. There are several comments about the HL7 Pedigree standard in here, and they noted that's it not … and wide adoption, and so they're not recommending anything in Stage 2 is what it comes down to.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Does someone want to put forward—one of the things you said David Bates was maybe focusing on essentially high-priority conditions where there's good evidence about the importance of family history as we know it now versus family history broadly, so that's one modification for the NPRM. Is that something you want to move or do you think we ought to family history?

David Bates – Brigham and Women's Hospital – Senior Vice President for Quality and Safety – Chief, Div. Internal Medicine

I actually find it acceptable the way that it's written here, and I think that gives organizations latitude. I think Josh ….

Josh Sharfstein – Maryland Department of Health and Mental Hygiene – Secretary

This is Josh. I think that even if there is not a standard ready for a functional capability you don't necessary need to have the standard running.

W

So David you're saying that because the threshold is 20% that gives you the ability to customize locally whether you're choosing breast cancer patients, colorectal, is that what you're saying?

David Bates – Brigham and Women's Hospital – Senior Vice President for Quality and Safety – Chief, Div. Internal Medicine

Yes, exactly.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. So I'm hearing a move towards accepting the NPRM as is, and let me see if that's widely accepted. Okay, so that's a change from our previous recommendation. Okay. I forgot to bring up your issue and do you want to state your issue?

Christine Bechtel – National Partnership for Women & Families – VP

Can I only have one?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

No, no. I mean the one that's out of sequence so far. Think of it as an addition.

Christine Bechtel – National Partnership for Women & Families – VP

Right. It's Christine. It may be that there are other issues that fall into the category but there are some programmatic dimensions in the rule that don't fall into an objective. And so going line-by-line through the criteria and objectives is great but we probably need to be clear about our position on those other things unless it's somehow the back of the nature … haven't gotten it there.

W

On page 33—are you taking about the core versus menu?—there is something about that but based upon what you had said you'll probably want to update the language that we have in there.

Christine Bechtel – National Partnership for Women & Families – VP

There's that, there's the one-year extension for the first group, and the other claimed to have programmatic dimensions are they cataloged here?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

We have the one you just … was mistake. Why don't you keep track of the ones that you want to have and we'll add in?

Christine Bechtel – National Partnership for Women & Families – VP

Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah. I think that the point is that there's a section of this towards the end, which this definitely could fall into and so it's something to keep on tab. Good. Okay. Now, we're on page 13 (making pretty good progress) out of 40. This is about progress notes and this is another one of the ones that we keep re-visiting. The NPRM does not have an objective for progress notes. It has been important to this group in the past. The Meaningful Use Workgroup was responding both to the NPRM rational. That rational, as I understood it, was that most systems have this already so we don't need an additional objective. It was the feeling of the Meaningful Use Workgroup that actually many of the systems, particularly hospitals, don't necessarily have then and they aren't necessarily used. And a lot of times important information, even problems, meds, and allergies are not adequately used and not kept up to date, etcetera, and that's one of the reasons they're so valuable. It's one of the reasons we've chosen to have them as Meaningful Use objectives. This probably falls into that bucket in the sense that it's important. It's important to quality. It's important to care and efficiency and that was the reason why we recommended that, again, it appear as an objective. Comments on that?

M

Yeah. I just don't understand why is the text searchable?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Text searchable was the offering in the NPRM in terms of that an EHR has the ability to search for text ….

M

I don't know that means search for text.

W

Inaudible.

Paul Egerman – Software Entrepreneur

… text or search within the text for certain things?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Maybe ONC can help us out.

M

Well, I think that as opposed to something that was a PDF that you didn't have a search, a non-searchable PDF, for example.

M

… would be, as I imagine would be the counterpoint.

Paul Egerman – Software Entrepreneur

My view is I agree with adding, you know, the progress notes and text. I don't think it necessarily has to be searchable. Just adding the searchable part is like yet another level of expectation, and the idea of adding text is it adds an additional, I don't know, element to the record that you can see something qualitative about the patient that might not otherwise fit into the objective, the approach, the whole thing.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Just for clarification, what do you have against being able to search the text?

Paul Egerman – Software Entrepreneur

I don't think that's necessarily has to be part of the recommendation. In other words, you can add it without saying it has to be searchable.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Before David kills over I want to give him a chance to respond.

David Bates – Brigham and Women's Hospital – Senior Vice President for Quality and Safety – Chief, Div. Internal Medicine

There are a variety of tools that let you search records now and if the text isn't searchable then there's just a lot of value that you can't gather from records.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think Paul's question is whether by this we are implying that there should be a certification requirement that you have a text search capability within an electronic health records or if the certification requirement is simply that this be recorded as key text as the standard in which it's used. So those are whether searching is an additional functionally requirement being implied here.

Paul Egerman – Software Entrepreneur

I'm not saying it doesn't add value. I'm just saying that's like an additional requirement. I mean it's two things; one is text, the other one is actual searching. I think you make a step forward if you have the text.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

To look at the NPRM we were just agreeing with the NPRM. Let's look at the NPRM and see what it's asking for.

Paul Egerman – Software Entrepreneur

I thought the NPRM did require it.

W

I think you might want to modify unique visits because my experience is that different healthcare organizations count visits in very different ways, and for some of them, especially those who may have a lot of this, it might be a big problem. Just simply the lab visits, the radiology visits, the allergy shot visits,

all sorts of things that add to their visit count. I think we really probably need more; 30% of unique visits to a decision making provider or something to that nature.

M
I think there's a definition and there is—

W
Oh, there is of the word 'visit' there, unique visits?

M
Right.

W
Okay, so we're okay.

M
Paul, can I clarify what we meant by this just to answer Paul's question. We were agreeing with the CMS NPRM which simply says that the ONC NPRM has a certification requirement that it allow the inclusion of searchable text and we say, "Good." We are not adding a new function and writing this sentence, so that needs to be clarified.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. Was there any question or comments on this side? So let me check whether there was consensus. I'm not sure I know whether there was consensus around what's written here. Are you—?

Paul Egerman – Software Entrepreneur
I'm okay with it now that I know … it says.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. So is there a consensus around the statements written here? Okay. Next one has to do—now, we're into the hospital labs. The objective was not included in the NPRM. The rational was that hospitals provide some of the electronic test results, private/commercial groups provide others, and just because the hospitals are part of the Meaningful Use Incentive Program doesn't necessarily mean that they should have an asymmetric requirement. That's sort of—if I'm paraphrasing the rational for not including that. On the other hand, the Meaningful Use Workgroup is looking at the importance of that 40%, and it is of course a requirement for EPs in hospitals to have that information in structured form. We thought it was important to have the hospitals, as part of their participation in Meaningful Use, deliver it in structured form in LOINC where available. That was the Meaningful Use Workgroup, and Micky, do you want to talk about the IE Workgroup?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes. So this was a recommendation that came last year from the IE Workgroup. I think it was then aligning with the Meaningful Use Workgroup, approved by the HIT Policy Committee. We still feel strongly about it, and I think I personally would also say when you think about the fragmentation of this part of the industry and the unique lever that we have over an area that highly fragmented otherwise, and the importance of lab results to multiple other things, which we're trying to achieve, I can't think of a single other objective that's as important as this one. We feel pretty strongly this should be brought back.

We do recommend that we not force ripping and replacing so we would grandfather existing interfaces because there certainly are some out there. But the idea would be that they need new interfaces and as they're sort of migrating towards to interfaces that they be according to the standards that are already required for electronic lab reporting to Public Health.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Comments, discussion? A lot of head nodding here. This has been a—yes?

M

Was there discussion about the scope question that addressed the question of whether this is within scope of Meaningful Use for hospitals because it's not their use of the lab data for their own purposes? It's in their function as a reference lab, as it were, for others.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

There wasn't. It was strongly assumed that this was within the scope.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I'm reading a lot of head nods. I think there's consensus about this. It's really that important. It may be a little bit of analogy to Public Health even though public health isn't in the Meaningful Use Program. It's so important that we get information and that we send, and that we're trying to adjust that.

M

Should we comments on the question that Farzad asked about how it fights into the hospitals and meaningful use of the system as part of our response because it does fit in, in my mind, because it's part of the hospital being like the responsible player for information exchange? That's why it fits for Meaningful Use for a hospital and maybe that's the missing link in the discussion here that makes this happen.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Good. The next one has to do with patients getting access to an electronic copy of their health information—that's been replaced, so we'll be discussing that later—and similar thing with the hospital discharge instructions. Okay. So we're moving into engage patients and families; same thing with provides timely access to their information. This is all coming under the view, download, and transmit function. Now, speaking of download and transmit, this is a new requirement for the NPRM, and it is talking about patients having ability to either access it online to download it online like the blue button function or to transmit it to their representative. This is calling for 50% of the patients being seen to be able to get that in a timely manner, so that's one point. The second point was to have 10% of people seen during a reporting period have actually done one of those view, download, or transmit.

There are two aspects to this. One is the 50% that have access to it, and that's sort of an EP responsibility; the second part is where the Meaningful Use—pardon me? NEH. And the second part is where the Meaningful Use Workgroup had a comment that 10% of patients seen during the reporting period have actually done one of those three. We thought that the more appropriate measure is to have a rising number of your patients using this online access, and the starting point that we proposed is that it would be 10% of your overall patients, your active patients; active being defined as seen within the last two years. That they have logged in. Not that they were given a registration form. Not that they filled out. They took all the procedures necessary to login, which means agreeing to the terms and conditions, authenticating yourself, and generating your security, your password basically and physically have gotten into the system and seen the data.

So that's the counterproposal for the 10% who have been seen have actually logged in. Is that clear, that 10% of your active patients have ever logged in?

W

But how's that different from the NPRM?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. The NPRM says, "10% of those seen during the reporting period," which is a different number than 10% of your active patient base, "have logged in," which is more a more stringent requirement. Part of the thought is this is a start and your building up. You're going to have more and more people over time, but it's much more achievable and meets the intent of the participation of the EP and the EH engaging patients to access their information online. That's the difference. It's sort of a …. So Gayle and Judy?

Gayle Harrell – Florida – House of Representatives

Thank you. This is Gayle. This always concerns me when we start requiring that providers are responsible for patients' behavior in doing something like this, especially in areas where you have a significant digital divide. This becomes extremely problematic.

I think what we're doing is better than the NPRM, you know, … you're saying active patients, so anybody who's been seen the last two years who at least logged on, you have a smaller pool—I mean a smaller number that you have to make do this.

I just worry so about it. Is this a menu item? Is this a requirement to meet meaningful use? Are you going to kick somebody out of the system because they had 9%—nobody had a computer, nobody had—you know, there are areas that this becomes extremely problematic. I'm just going to say my peace one more time.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. And I was remiss in giving Micky in the IE Workgroup a point to—

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Sure. We sort of followed along the lines of the Meaningful Use Workgroup; I think refined it just a little bit more. We didn't get into the conversation about whether it's active patients versus those seen this year. We just didn't discuss that.

But our recommendation is about one time—we called it registration. I'm not sure that we completely aligned the definitions. The idea of registration from the IE Workgroup perspective was the one time event where you do get your credentials, you create an account so you do get in, but the idea is that that doesn't mean that that patient has to physically log in every year.

It will be the one-time creation of account that they have to do, and that's why we also recommend that the threshold be increased over time. Because the idea is that's a one-time event and so you don't want to be counting the people who registered in the first year again the second year; you don't want to give credit—just say alright it's 10%, the same 10% of patients. So we recommend increasing that threshold 10%—starting at 10%, increase it five percentage points per year over the Stage 2 period to a maximum of 25%.

The overarching idea is that—consensus in the workgroup, including a number of providers who represent small practices, big practices, rural, urban, was that they felt confident that they could bring the technology to the patients in this way, but they would find it very difficult to make them use it on an ongoing basis.

We also heard from a relatively advanced practice in Massachusetts that said that they were having a difficult time getting over 23%. They were roughly in the 23% of patients using their patient portal, which had been sort of very aggressively marketed to their patients.

So there seemed to be sort of a sense of: (A) That they could get a certain degree of patients to register for these. A lot of hesitancy about ongoing use and a sense of, you know, there ought to be a reasonable cap because there are just some structural limitations, perhaps because of some of the things that Gayle had mentioned and other preference kinds of things that would limit their ability to keep going into their patient panel.

Marc Probst – Intermountain Healthcare – CIO

So just for clarification—this is Marc Probst. … registration - so the point was, one time ever, in terms of logged on. But you described, I think, all the way through logged on. But it's important to—

Judy?

Judy Faulkner – Epic Systems – Founder

A couple of things here. We had a meeting not long ago where this was the topic of conversation. And there were a lot of people who were very concerned about this, physicians representing different areas. That conversation continued for much of—for several days.

Some of the things that I thought were interesting were that some of the organizations that had a very large patient population and had a very high percentage of use still were worried about the others who weren't in that situation. Clearly, the digital divide came up. Not just the ability of the people, but a couple other things: One, areas where, in fact, there's very poor internet access. And another said, "I live in an Amish community." Do, therefore, we rule out all the hospitals and providers who are in Amish communities?

M

This is …. That was the one question that I had never gotten before.

Judy Faulkner – Epic Systems – Founder

But it is interesting. Because that means we rule …. The other thing, in addition—maybe this is covered and maybe we have it already written up in other rules, but if it's for every patient, what about the proxy access, where in fact the patient, him or herself, is not viewing the record but it's done by the parent for the child or the child for the elderly parent?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Deven?

Deven McGraw – Center for Democracy & Technology – Director

So we too, as you can imagine, have had extensive conversations about this and feel, actually, probably a little beleaguered, but fully understanding the concerns about making providers responsible for behavior of patients that they don't have full control over—

M

Describe who "we" is—you said "we" are concerned—

Deven McGraw – Center for Democracy & Technology – Director

So "we" being CDT, but you know, as membership of various consumer organizations. On the other hand, we've heard lots of anecdotal evidence, as well as testimony, from some of our hearings that absent the work by a provider to actively encourage and engage patients in using these tools, the numbers likely don't occur.

And so I think the idea of keeping this at a low threshold was based on the concept of – this is going to take some effort, and we want you to apply that effort and we'll keep the threshold relatively low. I think if we were not able to get consensus on a threshold measure in the Workgroup, we're not likely to get it here.

But I like presenting the ideas that have come through the Workgroups for potentially making this measure still meaningful, but easier to count for providers. In other words, trying to reach out and say, look, we get that you can't make—for example, on the ongoing access point, we can't control whether a patient continues to visit this portal once we've set them up with an account and they've seen it at least one time, right?

I'm trying to be as conciliatory as I can, but I think it's number one, removing that threshold - you won't get consensus on that. I'll tell you that right now. But trying to sort of understand the concerns and being somewhat creative, while still making sure the measure is meaningful, I think is what we're really struggling with.

I don't know whether we need to get consensus on all of those ideas—which might take awhile, or whether we just offer them as deliberations of the working groups about ways that might make this work better.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Christine, Neil, then David.

W

Actually Neil had a comment.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, Neil.

Neil Calman – Institute for Family Health – President & Cofounder

This is Neil Calman. I want to be even more radical than Deven.

Deven McGraw – Center for Democracy & Technology – Director

That's not hard.

Neil Calman – Institute for Family Health – President & Cofounder

I think the excuse that providers can't take responsibility for something that the patients have to do is ridiculous. We measure their outcome measures on diabetes, and yet if they don't exercise or take their medications, guess what? We're being measured for our diabetes outcomes. We're being measured for our hypertension outcomes, and if people don't take their medication, guess what?

But providers have a responsibility through education to move people in a direction that they need to be moved, and we're held accountable all the time for our ability to convince people to actually follow our recommendations. So this recommendation, which is critically important, is basically to have people get more involved in their own healthcare. And so we get them to sign up, but that's not really enough. And what you really need to do is to be able to show them how getting involved in monitoring their lab results and communicating with their providers actually will lead to better outcomes.

I think that this is a critically important part of what real meaningful use is, and we should not accept this excuse at all of providers basically saying, "Heck," you know, "I sign them up. It's not my responsibility whether they use them." That's like saying, "I wrote the prescription - it's not my responsibility to convince people that it's really important to take their medications. If they don't take it, too bad." So I think there's a real analogy in that. Having said that, I think setting a very low threshold is really important to get people moving in this direction.

The other thing I'll say is that people's passwords and access expire after they're not used for a while. So to say have you ever, ever signed up—you're basically counting people who really don't have access anymore. You gave them the password and signed them up a year ago; they no longer have access and we're giving them credit for basically signing somebody up a year ago who doesn't use the system and no longer has access to it. So I think we have to be a little bit more prescriptive about what that means.

And lastly, I'll just say we have some practices that have 90% of their people signed up but not 90% of them are using them because all you have to do is basically create a situation where people are handed a piece of paper and said here's a password. Here's what you're doing and we're going to sign you up. And you can sign up practically 100% of your people, but you'll get zero percentage of them using it.

So I don't think the sign up thing—I would rather set the threshold at 1% and really make it be use, where you don't count the time when they sign up and get their password, but people are actually using the system and that way you're sort of forcing the providers, I think, to develop workflows on their end where they can answer messages, create real functionality for people, and make the systems useful.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Christine?

Christine Bechtel – National Partnership for Women & Families – VP

So thanks, Neil. That was well put and very eloquent, and I won't repeat it. I will say, though, building on that that it's a lot harder to get me to exercise than to log onto a website one time. You got that going for you.

M

Stage 3.

Christine Bechtel – National Partnership for Women & Families – VP

And the other thing I'll say on that front is the Policy Committee has recommended this before, and we have them behind it so I'd hate to see us go back on that.

So in terms of the particulars, I agree and have said before we should ask CMS and ONC to consider an exclusion for broadband access, to Gayle's point. That makes sense to me. We've talked about that before. I don't see it here but I think it should be. We've talked about proxy access, and I think we have to be absolutely clear that it's patients or caregivers, no doubt about it.

In terms of registration, I agree with Neil that just getting registration is not enough. And it's not really in the spirit here also because the data's going to presumably build over time, and I'm not sure that at the point of registration you really have everything available to you yet. So I think something more meaningful than that was our intent.

I think that the denominator change accomplishes essentially lowering the 10% threshold, because the denominator change is going from patients seen in the reporting period to all active patients. So it is now lowering the threshold. And I'm okay with that, as I understand that. But I do want to say that I think the IE Workgroup, unfortunately, I do disagree, Micky, that we should count any time in the past for the reason that Neil stated.

I understand the spirit of that, and I think that it's probably something we should really look at for Stage 3 to figure out how do Stages 2 and 3 interact, because I think that's what that dimension of the Workgroup's consideration was really looking at, and I'm just not sure we got it right given Neil's point around password expiration. That would be my input.

M

Paul, can I clarify one thing?

I think Neil's point on the expiration dates, that's a good point. I would point out that I think, in a way, the two approaches, meaning what's in the NPRM and the one that we're suggesting, are really two different ways of looking at this question and what does it mean to really have patient participation in this or patient engagement? Because if you define view as being that registration, it just means that I've registered, that counts as a view, you could argue that I got 10% of those, and those same 10%, all they have to do is sort of view all the way through, that's counted for the first year. And now the same 10% essentially who just have to keep using it versus what we're suggesting is that you have to get 10% new patients in the first year, 5% new in the next year, so 15 total, 15% in the next year all the way up to 25, so you're actually bringing in a broader—assuming that their passwords haven't expired in that period, you're actually bringing in more to that one-time registration event, and you could get more actually actively using it of that 25% than the NPRM will get you.

Christine Bechtel – National Partnership for Women & Families – VP

It's Christine. I like that approach. I think what worries me is that when I registered for my portal at my physician practice, I got emailed to me my login information. But I didn't—I'm registered. I didn't have to actually go in and look at anything.

M

Well this—that wouldn't count.

M

Our recommendation—

Christine Bechtel – National Partnership for Women & Families – VP

Right. That's what I'm saying. We're talking about registration. That's what I'm—

M

No. Our recommendation is you have to log in.

Christine Bechtel – National Partnership for Women & Families – VP

Right. Okay. Right. If we're talking about login then I think that approach does make a lot more sense and there are new—as long as, over time, it changes to be new and additional patients that you can't double-count, before—and that's how it reads, is you're counting previous logon events. That's what I'm—

M

Well if you look at the IE Workgroup, that's why we have a graduated increase over time.

Christine Bechtel – National Partnership for Women & Families – VP

Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. David Lansky?

David Lansky – Pacific Business Group on Health – President & CEO

I also support Neil and Christine's comments and direction, but I also think our focus here should be to make sure the functionality is in place, and that some people have used it so we know it's working. But that should push us back to the quality measurement side that we should be measuring whether people are having effective access to their information from their point of view. And if they're Amish or whatever the circumstances, there may be other modalities we expect clinicians to be using to achieve that goal. This is a very important one in that toolkit.

So as long as we've got a threshold here which assures meaningful capability is in place, then we also have to equally pressure CNS and ONC to make sure the patient experience component of the quality measures are more robust than they are now. Because right now we're not able to measure whether patients are getting meaningful use of the information.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

David Bates?

David Bates – Brigham and Women's Hospital – Senior Vice President for Quality and Safety – Chief, Div. Internal Medicine

I also agree that this is important. It's been interesting going through this in our organization. This has gotten everybody's attention finally, which is good. Some people thought that they could ignore this whole area. I do think it's important to set a threshold. I think it should be low, and it's really important that it be realistic. It's tricky making it realistic.

I would be okay with either the ten or the ten going up to 25. I would give people credit even if they log in one time. There are many people who don't need to go to see the doctor every year. There are a lot of people who go every three or five years. If you're not going to do that then you have to just do a better job of defining the denominator and saying what is an active patient.

If you look at the distribution of how often people actually use these things, which we've been doing on a regular basis, a lot of people really like it. They value it. But they don't go in very often and I think that should be okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Judy?

Judy Faulkner – Epic Systems – Founder

Our experience is that the 25% would be very high. And we've watched it over years, and we watch it by different organizations, and that would be high. And when we even look at those who do a lot of advertising, a lot of one-on-one physician-to-patient, we still see typically below 50%, so I'm concerned that having within a few years a goal of 25 is going to be too high.

I also think that we should have a carve out allowed for the digital divide. And I really do want to ask—I mentioned before but I haven't had an answer, I personally don't use it, which is interesting because my husband does. If I need a prescription I say, "Can you go get it?" In most households—

M

Everybody needs a husband.

Judy Faulkner – Epic Systems – Founder

And a wife too, yes. In most households the woman is managing it, so if you have five people in the household, and the woman is one of those five, you're only going to get one who logs on. So how do you deal with that in this?

M

I think you should just count for proxy, as you suggested before. I think proxy should count exactly the same.

Judy Faulkner – Epic Systems – Founder

So if it's every record touched, not every person who touches a record, then that's a different twist on it. But that's a much better way to do it. I still feel, though, that 25% is going to be high.

M

Okay, can I go? Great. Okay. I'll speak a little bit from experience as well. We've been doing this for 12 years. We have three-quarters of our patients online, and I wanted to speak—one, the good news—it's a try it, you'll like it kind of a function, actually. So part of that means that you do have to get people started. The other is it's far easier to get them to like this than getting to like an EHR because there's so much positive feedback on both sides, both the patients and the physicians like this. Those are the good news. But I'd agree with Judy that it's really—you don't want to put people off to getting started, and once you get started I think there will be some momentum.

With respect to the IE Workgroup in terms of the by year increments, it seems like that adds a bit of complexity that may or may not be necessary, but certainly we can move it up with Stage 3, for example. But it is a functionality that you need to overcome the initial inertia, but then I think it starts to carry its own weight.

So, Christine and Gayle?

Christine Bechtel – National Partnership for Women & Families – VP

Coming back to the denominator change, it occurred to me—we were talking about shifting from patients seen to active patients, and it occurs to me that would only apply to EPs, I believe, because for EHs it's got to be patients seen. So I wanted to flag that.

And then I would say in terms of the use data, we did do a national survey of almost 2,000 consumers, and of the ones whose docs have EHRs and they have portal access, 48% used it three times a year or more, 80% used it overall.

Gayle Harrell – Florida – House of Representatives

I just want to make one more comment about the 25%. I think that is overwhelming and you will just have a lot, super amount of pushback on getting to 25%.

M

Where's 25% coming from?

Gayle Harrell – Florida – House of Representatives

No—well there was that whole discussion about gradually moving up. I think the IE Workgroup had said moving on up to 25%. I do want to comment that I think that would be very, very difficult, even on a moving it up year by year. I hope that we never get to that point.

Secondly, I want to say again for the small specialist in certain areas—you've got to count especially those that deal with one-time incidents—surgeons and orthopedists and things of that sort, that there may not be followup on. You're lucky to get somebody at a one-time shot to go in and even sign in. So it varies. PCP, where you have ongoing tests and ongoing relationships, it becomes much easier. With speciality areas, it becomes extremely problematic. So the lower we can keep this, the better.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Can I just clarify? This is Micky—sorry, on the 25%. So we did look at information and got information from members of the Workgroup. You certainly have large organizations who've been doing this for a while—Group Health, Kaiser, others who are very, very high—I mean, 70%, 80%, 90%. But then all the way at the other end of the spectrum, the small providers and others. But we do have sort of representation on the Workgroup from, as I said, from providers in small practices, larger practices, rural, urban. And there was a sense that if we restricted this to the one-time registration and graduated over time, that it would be a challenge but it was achievable because they felt that those were things that were relatively in their control.

That's the only comment I would offer. I mean, there was recognition the 25% over time would certainly be a challenge, but the idea is graduating it up—the clinicians, at least represented on the Workgroup, felt that that was sort of an appropriate challenge, an appropriate stress challenge to put out there.

M

So just a suggestion to help us move forward would be that we just—I don't see any reason why we need to call out a number for four years from now. I think we should basically say—call out what we're suggesting now and say a number that we would recommend gradually increasing over time. And I think that would take that whole discussion about 25% four years from now—because we're talking 10%, 15%, 20%—and we don't really have the authority to do that now anyway, right? For four years from now to call out a number that's going to—?

So, I would just say that we put something in right now that would basically—that we just call out the 10% number or less—but that we just speak to what we're talking about right at this point.

Marc Probst – Intermountain Healthcare – CIO

Paul, this is Marc. Can you hear me?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes, go ahead.

Marc Probst – Intermountain Healthcare – CIO

So just one statement; one question. The statement is - all of these requirements, and particularly something like this, there's a lot of logistical work within the practice so the concept of doing this is really excellent, and I agree—it provides toward meaningful use. But there are a lot of logistical things that have to happen within a practice or a facility to allow this to occur legally and appropriately with the right security. So that's just a comment that we should be sensitive of, and I think we are.

The question is around proxy. It seems to me as we did proxy, it became very, very challenging with children and particularly children from—I forget the exact term but it's essentially when … occur, when they're young enough but they're still not adults. Have we addressed or understand well enough those issues in regards to our thinking around proxy?

Deven McGraw – Center for Democracy & Technology – Director

Can I respond to that?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, Deven

Deven McGraw – Center for Democracy & Technology – Director

Marc, this is Deven. All we're doing is allowing people to count access to a patient's record that might be via family member and allowing the institutions to do their own policymaking about establishing portals for the patient in the sort of preteen-adolescence phase where there are obviously some complicated issues about who can access that data and can't, and it varies by state.

So it's really about what are you able to count versus declaring a policy that says you must have proxy access. Does that make sense?

Marc Probst – Intermountain Healthcare – CIO

Yes, it does. Just as long as we're thinking—as we're thinking about 10% and what Neil just said probably answers my question, too. The thing about percentages—proxy really isn't very easy. I know in our state, it's been incredibly difficult. And to manage that legally from just getting all the approvals appropriate and managing those approvals on a very timely basis is pretty extensive.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, Judy?

Judy Faulkner – Epic Systems – Founder

Many of our users—I don't know if the word is many, I certainly know a number of our users, actually don't allow access to the patient's record when the patient is in those teenage years, feeling that neither the adult nor the patient … appropriate. I think that number should be carved out for those who do that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. I think there is some consensus, or at least there's leading momentum. Let me try to describe what I'm hearing as the train that seems to be leaving and see if you agree. That one, we define it by—let me use the term logon, Micky, because I think it's a little clearer what the act is. That two would be for your entire active patient base, not just those seen. And three, that it be 10% for Stage 2.

Judy Faulkner – Epic Systems – Founder

What was the second, Paul? Logon was the first.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

That 10% of your active patient base, those seen within the past two years for EPs, have logged on—and 10% of those people have done that.

Let me see—are we getting close to that?

M

Paul, just remind me. Is this our menu item or is this core?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

No, this is core.

M

This is core. So to Gayle's point about specialists, there are specialists whose patients are never going to use a portal.

Gayle Harrell – Florida – House of Representatives

Never going to use a portal.

M

Others will use it a lot. But there's some that will never use it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Let me ask one possibility. So like in a procedure list, you could leverage this, for sure, to do the upfront patient instructions and the followup afterward. So it could—even though it's an episode, it certainly could be leveraged to do some important information then. Christine?

Christine Bechtel – National Partnership for Women & Families – VP

We thought about that too, and I do have the same concern but from the other side of I don't want patients to have 17,000 portals all over the place. But the IE Workgroup provided a really nice solution which is that the numerator—you could count two options, because remember - it's view, download, or transmit. So, you could allow in lieu of the portal logon, you could allow for the provider to transmit the health information to the place of the patient's choosing, whether it's My Portal or PHR or whatever, that if you have a specialty that you could allow that, or to their direct email or whatever it is. Yes. And I think that makes sense, so I'd be happy to have that added in, if that would provide a more—

M

That's a small number.

Christine Bechtel – National Partnership for Women & Families – VP

I'm sorry?

M

…small number.

Judy Faulkner – Epic Systems – Founder

Paul, if we agree to this then what about, have we agreed to it without a carve out for certain things such as the digital divide, the Amish, or taking out the kids in a certain age range as part of your total number?

M

Paul, I was going to say that there were two other things I heard. One was around proxy access counting, and the second was around the broadband exclusion.

So let's assume the broadband applies universally. So the broadband's covered separately and it applies universally and there's already an FCC designation. The carve out for things that are universal, such as the adolescents, basically, because that is such an important state-based issue, that seems reasonable and it's universal.

I don't know what to do about individual cultural aspects. The Amish was brought up—I don't know how to—

M

I think that you can certainly say that there may be rare instances where things—that should be addressed. There is the opportunity for hardship exemptions for unusual situations, more broadly in any case.

It would be an interesting—but maybe not that fruitful or productive exercise to see how many providers have more than 90% of their patients be Amish. I think it was just a very particular scenario so wouldn't spend—

M

Okay. So let me try to recap that and see if—

Madhu Agarwal – Department of Veterans Affairs

Just one last comment. This is Madhu Agarwal. We've been pushing patient registration and authentication, and MyhealtheVet, which is our—the VA's web portal for quite some time. And at this time we have roughly—actually a little over 700,000 folks who are involved in it.

So the question is that many of them are also dual users. So, they come to the VA; they also go to other practitioners and practices outside. How is this going to work for that dual user, or people who are going to different practices or different systems for health care?

M

Well normally—let's say there's two, you and a specialist. Then both EPs would be responsible for having 10% of their patients log in. And in fact, it's fairly straightforward to get this single individual to log in to both—

M

I think Deven—it was Deven, about the transmit?

Christine Bechtel – National Partnership for Women & Families – VP

That was my point.

M

Oh, sorry. Christine's point about transmit was maybe highly relevant here, where an individual may want to designate one area, whether it's tethered to a particular provider, the personal health record, or independent personally controlled health record as their designated electronic medical home, and to have that be the place where they have their documents from multiple providers be sent to as a permissible option, I think is what I heard, to make sure that that is clearly captured.

Gayle?

Gayle Harrell – Florida – House of Representatives

A clarification on that. This is Gayle. If you are sent a secure email, if you're on direct, does that count? Would that count?

M

That's the proposal, is that if a specialist sends the patient—transmits to the patient—

Gayle Harrell – Florida – House of Representatives

If the specialist initiated it and transmits to the—

M

A care summary—

Gayle Harrell – Florida – House of Representatives

A care summary—

M

To their personally controlled health record account using secure communication.

Gayle Harrell – Florida – House of Representatives

If they have a personal health record account.

M

If the patient has that. If the patient has that.

Gayle Harrell – Florida – House of Representatives

What if they don't?

W

Then this portal—then the specialist may have a portal.

Deven McGraw – Center for Democracy & Technology – Director

This is Deven. I thought the idea was not to sort of force patients to open up PHR accounts in order to take advantage of this, but if they wanted to have the data sent to a PHR account, or if they have a direct address, then they could do that.

But the idea of the view and download capability in EHRs was to allow people to have an option that would number one, be HIPAA-covered, and they would be able to access their data. They would have an option from a patient standpoint to be able to transmit it, but that a provider can't meet this functionality by saying to patient, "Tell me what PHR to send it to and I'll get it to you."

M

I think there was actually an interesting blog by John Halamka, where he describes the process for someone without—who comes in who does not already have a secure personal health record account but has email, of being able to subscribe them and initiate the secure transmission very easily into having a direct endpoint through …. So, it may be more feasible in workflow for specialists to do that. If the person has an email account, then it might be to establish the portal login and so forth, so—

Gayle Harrell – Florida – House of Representatives

And all I'm suggesting is that people, that we could count both in the numerator according to what the patient wants. It's not one or the other. You can count them both.

Deven McGraw – Center for Democracy & Technology – Director

Yes. Yes. You can count them. That's absolutely right. Yes.

M

Okay, I'm going to try—Larry?

Larry Wolf - Kindred Healthcare - Health IT Strategist

So maybe this is creating too big an entryway here, but maybe this also addresses current practice. So if I see a specialist and I say, don't send it to me, make sure my PCP gets this and I can access it through the PCP here. This is different than I had been thinking about what transmit was. But it actually kind of addresses common practice, and might help get better communication between the specialist and the PCP by my saying, "Oh – you're going to get credit. You'll get your credit for your meaningful use." Like I'm going to know that, right? — by providing information back to the primary care doc. And that also, I think, would create more … around whoever the primary provider is for me to get that information and for me to have a reason to want to use it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. So let me try to summarize. And I'll try to even summarize in a measure format, meaning numerator and denominator. So, wish me luck.

Okay, in the denominator would be all active patients, that is for EPs all patients seen in the last two years minus those in the adolescent category, that's state-defined so it's typically between 12 and 18.

And then in the numerator would be those records that have been accessed through a login at any point in time, proxy access to that patient's record counts, and that numerator, that ratio, would have to be 10% or greater.

There is already existing carve outs for those missing broadband access uniformly and there's also provisions for special hardship cases, which could take into account some of these ….

M

The numerator also would include transmission….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And your access—there's some way that your information, the information of that record, which counts for proxy, is viewed, downloaded, or transmitted in a way that's accessible to the patient. So it's not just that they transmitted it to the PCP, they have to have the ability to view it, to access it.

How am I doing? Is that clear, for one?

Okay, now second—do people …. All in favor? Do we even have consensus? It sounds like we really—okay. Great.

… lunch. That's a special technique of holding … because there's a second part that we didn't do yet which is the 50%. And the only mod that the meaningful use, and I don't think IE commented on this was the timeline. So it was a proposal in the NPRM that says look, the immediate plus the four days when it becomes available, it just gets too complex so they suggested one timeline. They happened to pick four business days. Meaningful Use wanted to shorten it a bit to two business days because that's very reasonable. It even accounts for a weekend. And that's the only change. Do people agree with that? Keeping everything else the same?

And that looks like a yes. You're the one that wanted lunch.

M

Within the two days, are you talking about the note as well? Because the note's not necessarily going to be available. I assume that the note is left out of it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

The note actually is not one of those that …. In fact, it doesn't even appear in the EHR. Okay. So I think we finished this one off, and thank you so much for your forbearance. What if we went for a 45 minute lunch, so we reconvene at one o'clock? We're on page 17 out of 40, so we just have to keep making progress. Thank you.

(Lunch taken)

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor If everybody would take their seats, we're going to start. Please take your seats. Operator, would you open the lines, please?

Operator

Lines are bridged.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

Thank you very much, operator. Back to you, Paul.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. Thank you, everyone for resuming. As you can tell, we really only have an hour left on this part, and we have 23 pages to go through. So, we're going to have to take some—one, we're going to take some cooperation by the group. Thank you. We did get through a lot in the morning session.

We're going to skip over the comments per se, things that we've already reviewed with you last time and took in your feedback, which didn't really change much since last month. So, where we left off is page—this occurred to me because I was looking through some notes. The five CDS things that we're calling out for people to do, one of the discussions we had was the thought of having one of them be something that relates to an efficiency.

Remember, we talked about the fact that efficiency is in the heading, but we didn't really have anything in that whole section that deals with efficiency. So, they would be pretty simple to just basically specify one of them to say that one of the five measures, the CDS measures that we're expecting people to implement be something related to improve the efficiency. In fact, I thought we had talked about that at one point.

M

He had that in the comments. I'm not sure whether I get—did I?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I missed it. So, I'll look back. What we said last time was one, they did propose a DDI, drug/drug interaction was included in CDS and we agreed with that to the flexibility around these five attributes, but three, the thing we would propose to add was the measure on efficiency. Did I just miss that?

W

I updated them. It probably is back in the Meaningful Use Workgroup comments. So, I can pull it back here and make sure that everybody reviews it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. You'll be at it. We had agreement when we discussed it last month. So, it's just logistically missed. Okay. We're on page 17, and we are now on clinical summaries. This occurs after a visit with the EP.

There's really no change except for, and we talked about this last time, moving the calendar instead of four calendar days to two business days is basically to achieve a single timeline, single less confusing timeline. This, of course, doesn't prevent people from handing it to them as they leave the room, which is what we'd expect most things to happen, but there's an outside timeline.

Next one is patient-specific education resources. There was no change from the Meaningful Use Workgroup agreed with the NPRM. So, there's no change there.

Next one has to do with secure online messaging. This is the piecework we raised. Some point of discussion was around what percent of patients need to have sent in a message to their physician.

The workgroup last time recommended lowering the threshold from 10% of patients seen during the reporting period to 5%, which is one of the calculations. We're calculating that as 10% of the 50% that you need to use the portal. So, that's the Meaningful Use perspective. The Value Workgroup had a different perspective.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

We're sort of getting at the same thing, but we have a little bit of a different take on it, which was specifically about the same principle as on the view, download transmit that there was a strong sense among the group that we could bring the patients to the technology by getting them to use it in an ongoing way was sort of the second step, and let's go for the proximate step first. In this case, the proximate step was to say that provider-initiated messages should be counted as well with the idea being in some anecdotal evidence from members of the workgroup, both from the provider side as well as on the vendor side, saying that the greatest lever for getting patient use of secure messaging was for providers to use secure messaging. So, the recommendation from the workgroup was to allow provider-initiated messages for clinically relevant messages and not just blast messages about anything, but for clinically relevant messages to include that in the numerator, recognizing that we have patient reminders and all of that as other objectives. I think the thought in the workgroup around that because we specifically talked

about that was that those aren't identical. The patient reminder requirement isn't identical to this, and if there's some overlap that allows some providers to get a two-fer for some subset of that that that's okay. In principle, there shouldn't be a problem with that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So, just respond to the Meaningful Use Workgroup thought about this as well, and really the intent of this and the spirit of this is really to have patients have convenient access to the health team. Whatever mechanisms that, in best practices, the provider has to simulate that is certainly open, but the measurably is what the patient initiates. So, with a low threshold, that would get us to cross the activation energy in that regard. Then, not having to deal with what's clinically relevant, etc. Open for comments. Gayle?

Gayle Harrell – Florida – House of Representatives

Yes. Thank you. Once again, I want to emphasize all the parameters that we discussed under the view and download. We have the same problems with a secure e-mail or however you want to phrase it. So, I think that we need to preface everything with digital divide, no connectivity, broadband for access problems, everything again.

So, I think we're going down that same road again. It becomes problematic and difficult for it. I think in what we state, we need to preface everything with that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Other comments? So, the words on the page, and I think we'll sort of differ to the Meaningful Use Workgroup for this particular one would be the 5% threshold patient initiative only counting in the numerator. Do we have agreement around that? Okay, good.

Next one has to do with patient preferences for communication. The objective was not included in the NPRM. Meaningful Use Workgroup felt that this is a stage because as we get to more and more efficient communication mechanisms, you obviously need to have a record of what the patient's preference is, and then, other measures actually can feed on that. So, when you talk about providing them patient-specific resources communication, if you go through their preferred mechanism, things are one, more efficient and two, the patient's preference. That was the rationale behind that from the Meaningful Use Workgroup's point of view. Comments, discussion?

Christine Bechtel – National Partnership for Women & Families – VP

I support that, but I didn't know and I couldn't recall if we talked about it being ... or core, and I think if we're going to propose an objective ....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think it's core.

Christine Bechtel – National Partnership for Women & Families – VP

I think it's core too because of the secure messaging component, agree.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, fine with that. Next one is now, we're getting into care coordination. Now, we're getting into HIE. It's both valued to difficult. To express the difficulty, we have two different views.

We all agree with the NPRM rationale that says wow, this was—it seemed like a straightforward thing and the intent really was to just get it into certification criteria. The way to do that was to create an objective and to have the word test, which means people had to be capable of what turned out to be very confusing for people and actually the confusion and the effort versus the benefit wasn't holding up. So, both the workgroups are agreeing to eliminate the tests.

There were four options presented in the NPRM. So, the Meaningful Use Workgroup went with option four, which was to substitute tests for actually doing a real live successful transmission. Micky, do you want to talk about the IE Workgroup?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Sure. The IE Workgroup perspective when we did take the comments back from the last Policy Committee Meeting and had a successive conversation about it, but we did have a consensus in the workgroup to come back with the original proposal, which was to agree with the NPRM to remove it without replacement. Basically the rationale is that we have very few levers with respect to Meaningful Use. So, we want to use each one to the greatest ... and make sure that those are all valuable things that are moving the ball forward. In this particular case, it's a pretty strong sense among the workgroup that these single tests kinds of things really don't achieve a meaningful behavioral objective with respect to what providers are doing and that all they end up doing is being a check-the-box thing that the vendor for the most part just accomplishes for the provider.

I think that from the workgroup perspective, that has two bad effects. One is it uses up one valuable lever that we could perhaps use in other places. Two, I think it has a slightly corrosive effect on the provider community at large who starts to see these things as just check-the-box things that are essentially meaningless. So, that's why we came back and just recommended agreement with the NPRM.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Comments/discussion? Christine?

Christine Bechtel – National Partnership for Women & Families – VP

So, we talked about that and it occurred to me—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I almost thought you weren't going to say anything.

Christine Bechtel – National Partnership for Women & Families – VP

There are so many things I could say here. So, there were a couple of other options, right? One was remove without replacement. One was one case, but the other two, I think, had more substance to them and more transmission of in other words the care summary to a larger number. So, did you guys consider that? Because I get what you're saying about the limited number of levers, but I think I have two major issues.

One is the number of models of care and the number of consumer complaints that we hear about the lack of care coordination, so really needing to drive that is really actually their number one, number two consumer concerns are communication and coordination. So, to me, this isn't the lever you drop, but I get the point that just having a one-off option is maybe not the best, but my concern is also that Stage 1 is Stage 1 for like perpetuity. So, in five years from now, somebody can be coming on in Stage 1 or in three years from now, they can be coming on and doing Stage 1 and having no requirement around care coordination. So, did you consider the other options that would be even more robust?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes, and I think we did. We didn't go through them one by one, but I think the general sense was that taking the leap to essentially start imposing things on Stage 1, so remembering that these are Stage 1 requirements that that was really too big a step up in terms of saying not only do you have to do it. You have to essentially accelerate Stage 2 to those stages, so that's Stage 1 cohort.

So, the idea was that they're going to have technology that's going to have the ability to do these kinds of transactions. Now, assuming that they upgrade to the 2014 edition certified version even though they're somewhere in phase one, that will vary by vendor about whether they actually have to do that or not, but some subset, significant subset will have that technology available to them and it's a shrinking cohort. So, just trying to do the math on what we heard this morning from CMS, it looked like something on the order of 40% of Medicare eligible providers have already registered for Stage 1 and that's only in the first year and this year is going to be the big push.

So, Stage 1 will continue for a long time, but it's going to be a shrinking cohort and it may be that the majority are actually already registered for Stage 1 by the end of this year, which will be the big push

because next year is when they start getting declining payments for Meaningful Use. So, it was really all those thoughts that there was a strong enough push in Stage 2, a number of them will have the technology in place to be able to do it and at the shrinking cohort over time.

M

For the record, just to answer your question, one is drop the objective. Two is require that the test be successful. You don't just test, but it has to work. Three is you have to pick either med reconciliation or summary of care record transmittal as one of your Stage 1 menu items to prove you're doing something. That was the third option, and the fourth is the one that one actual case of electronic transmission of a summary of care record.

W

..., George. ... or Josh, if you start in Stage 1 and stop, can you avoid the payment penalty?

M

What we propose the penalty for 2015 would be predicated on either successful attainment of Meaningful Use for the full year in 2013 or if it's your first year and you attest for 90 days in 2014, by I think it's June 1st if you're a hospital, October 1st if you're an EP. So, whether you get hit with the penalty in 2015 depends on whether you were a meaningful user in 2014 or 2013 if you were already a meaningful user.

W

Which could be stage one. So, for the subsequent year, they do need to move.

M

Yes.

W

Okay. That's helpful.

M

I'm not sure if I quite understood, Micky, what you were saying in terms of Stage 1 providers optionally upgrading to the 2014 edition. After 2014, I think the proposal on the table is that after 2014, everybody, including those who are entering in Stage 1 would be using 2014 edition certified software.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Okay. That was mistaken. That strengthens the case, I think.

M

After two years, you move from Stage 1 to Stage 2 under the proposed.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So, I think we have two options before us. So, let's just see where people stand. One is to drop it and not replace, and the other is to drop it and replace it with a one successful transmission. All those in favor of drop it and not replace, which is the NPRM position? Three, okay.

Those in favor of the drop and replace with a one successful transmission of the CDA? Six, okay. So, we have a clear majority in favor of the latter. Thank you. Move on then.

This is med reconciliation, and the caveats here we talked about—this is at the 65% level, and the caveats that the Meaningful Use Workgroup offered was one, in order to know there's a transition which requires a reconciliation, they have to actually have new documentation requirement for the physician's, the EPs. The definition of a transition is pretty clear in the numerator, and so that helps a lot. Then, the recommendation from the Meaningful Use Workgroup was to lower the threshold from 65% to 50% because it's to accommodate the fact that sometimes the transitions don't require a med reconciliation, maybe the specialty, maybe the clinical situation, and that gives a little bit more leeway if it's 50% versus 65%. IE Workgroup, Micky?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

I'm sorry. This was the med rec? I think that overall because this is being made core requirement, there was just a general comment that greater definition should be given to the exclusion criteria for specialists.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Comments/discussion? Yes, Gayle?

Gayle Harrell – Florida – House of Representatives

I just want to reiterate how important that is because there are many, many specialists for whom this becomes could be problematic, and the 50% then gives some leeway but also the clarification for exclusion.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

How would you define it, or we just leave that as ...?

W

Let me just add one thing, but correct me if I'm wrong, Paul, but in the Meaningful Use Workgroup, that was actually part of the rationale for dropping the threshold was so that it would cover those exclusions without having to go through a defining process.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So, it looks like we're in general agreement with all of the ones, let's say, in the Meaningful Use Workgroup, and let's just take a sense of 50% versus 65%. So, those in favor of retaining the 65% from the NPRM? And those favoring the 50%? Looks like it's unanimous there. Thank you.

We're moving onto summary of care record. So, this is during a transition, it's provider to provider and there are a defined set of elements that are part of a summary of care document. The ask is that 65% of the time, this document is produced, and that can be paper or electronically, and in 10% of the time, it would be produced electronically, and in the NPRM statement, it would be cross-organizational boundaries and EHR both barriers and boundaries.

So, the Meaningful Use Workgroup was in agreement with the point of this objective except for the cross EHR vendor boundaries. The thinking there was that there could be some downside to that. We certainly understood the need for standards and the ability to exchange with anybody, all comers, but there are some geographic regions where it actually there's a reverse incentive to have to talk to a different EHR for different organizations just to pass this versus going with their clinical trading partner, despite the fact that they share the same EHR vendor. We could not come up with a consensus on countable number versus percent, so the 10% became an issue. Micky, do you want to talk about IE Workgroup?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

We didn't talk specifically about the countable number versus percent, but I think just by the tone of the conversation, the question never came up. So, I guess we're sort of implicitly in agreement with the percent. We agreed with the Meaningful Use Workgroup, which if I'm understanding correctly here about removing the cross vendor requirement for the 10%, if I'm understanding, the Meaningful Use Workgroup also agrees with that. Then, we also recommend excluding from the measure denominator query retrieve type of capability as counting toward that as well.

So, the idea was let's not—while we overall want to be encouraging for those providers who are moving to the next step, which they move me on push to query retrieve, it was problematic in a number of ways as you think about the measures, you think about the intents of what this is trying to get at. So, we thought that upon reflection that it should count in the same way that providing access to the EHR is taken out of the denominator for the 65%, it seemed to be equivalent here.

They were basically saying that's another form of providing access to your EHR. So don't give them credit for it, but don't count let it count against them either. So, take that out of the denominator just like you were taking out the access to EHR for the 65%.

M

Next question on your query retrieve, does it count if you have to log into a separate flow, like a log in to somebody else's EHR versus getting it through your native EHR?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

So, what we were focused on was planned transitions of care, first of because we entertain a number in the workgroups and the conversation was about the ED scenario. Someone shows up in the ED. The hospital then queries an ambulatory system. We thought, wait a minute. That's actually a use case that's probably not what we're considering here because that's not a planned transition of care.

Now, we could argue about whether that should be included or not, but that was kind of the idea. But the idea was that if what the intent is is to have the provider who is sending a patient to another care setting, if the responsibility should be on them to make sure that the information is being made available at the appropriate time, that that should rule out, or at least just take them out of the equation, those cases where there is a query retrieve function that would allow the receiving provider to be able to query the sending provider's system because the idea was there was no notification necessarily that would alert them to the fact that someone is coming to see you. So, there was a timing question that seemed like it was absolving the sending provider of the responsibility to make sure that the receiving provider or the specialist, whoever it is, actually knew that the information was coming, and this was made available and they should be alert to it.

So, it did take into account and that's part of our last point, but I think that's in here or it might have been somehow pushed on the other one. We did allow for cases where you have health information exchange type activities that allow subscription. So, it was just another form of pushing. So, you have models where there is repository-type function, something like that, or it could be a more of a peer-to-peer type thing, but the providers can subscribe to information coming from other providers. So, in that case, that would just be another form of pushing from one to another. So, we said you should count those, but you should remove from the denominator and just not count query-type functions.

M

In terms of where the NPRM—I characterized the NPRM current state at the Standards Committee in response to Chris Chute, the way I characterized it was that there's a transition of care, for example, a patient discharged from the hospital, that counts in the denominator and all of those transitions of care would count in the denominator, that whether the information was exchanged either by push or, this was my interpretation of what the NPRM says, or if using either the optional EHR certification criteria using the SOAP/SAML standards or using the NWHIN nationally validated entity provision for Meaningful Use, that that transition of information would count, whether it was pushed using the Direct protocols or pulled using a SOAP/SAML or NWHIN organization, the credit would go not to the puller but to the pulled in that scenario so, just to provide you the same interpretation I gave the Standards Committee in terms of what the current NPRM based on what we said on certification and Meaningful Use would stand.

M

As we started to get ground down and those kinds of questions about who would the credit go to, how would you actually be able to measure that, that we then went back to well, maybe we should just take the example that was set on the access to the EHR for the 65% and just take these out of the denominator. That was kind of the idea.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

This is George Hripcsak. What we're doing with the denominator depends in part on what really the goal is here. One goal is care coordination. We want to make sure that this is where we stuck the care team and the care plan.

So, if we take it out of the denominator, do we not need a care plan and a care team for that patient because they can query? So, is the goal care coordination, or is the goal HIE? That changes what you might want the denominator to be. So, for example, if you take it out of the electronic denominator, does

that mean I still have to send a paper version because they can query it, or like so how do those two things interact?

M

Just point of clarification, Micky, is are you proposing to exclude from the denominator any discharges that from the hospital, let's take the hospital case for now, any discharges where the person went to a primary care provider who has access to potentially pull the information, or is it to remove it in instances where the primary care provider actually did pull the information for that?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

So, this would exclude those because I think that's consistent with—

M

Exclude which, A or B?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

B.

M

Not A. Not potentially have access to pull, but would exclude those in which it was actually pulled.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Let me do it the other way. It would only count the cases where a discharge summary was pushed to the primary care provider.

M

I'm asking about the denominator.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

It would take out those cases where—so, your question is whether it was accessible or accessed? So, I think it would take out those that are accessed in that way.

M

How do you do the timing?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

I'm sorry?

M

I thought you said those with query access. So, that just access would be excluded.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Yes, I think that's right. So, maybe I'm getting caught up in the language here. So, those with query access would be excluded.

M

There are a number of elements here. I'm going to try to go from consensus to challenging where we might have to have a vote. So, one of them is I think it is true that the fact that we're going to call out these transitions is somehow there has to be a documentation that a transition is about to happen to qualify for the denominator. That's just a consequence of having this measure.

The second one is both workgroups agreed that there would be significant unintended consequences to requiring crossing of EHR vendor products in the transition. Am I getting nods for that one? Okay.

M

... a question. I thought we're still requiring them to use a standard way of transmitting that information, correct?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Correct. That should be for certification standard. So, don't ... just because they've developed some way of communicating amongst their own product. They have to follow the standards, but they won't be penalized for having to transmit the information to another organization that happens to use the same EHR.

We are all in agreement that we would require crossing organizational boundaries. Now, we're getting onto the 50% versus 65%, and let me test that one. The proposal is to lower to 50%. Is there agreement?

W

I don't.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

You don't? So, do we want to vote? All those in favor of lowering it to 50%? Nine. All those opposed? Two. ....

Now, we're talking about the denominator. The denominator in the NPRM, I believe is all those who go through a transition as described in the NPRM and alternative denominator are all those who go through transition where there is not query access to the referring.

M

The denominator to the 50% or just denominator for the 10%?

M

Yes, because they're different.

M

So, for the 50%, which was the 65%, I believe that the NPRM says that if you provide access to the EHR, you exclude that from the denominator. That's for the 65%, correct? That's what we were basing our thought process on as it relates to the 10%. Maybe we should get that language out first.

M

Who knows? We're checking. They're checking. So, in a place like in New York City now where there's query access from almost all of the voluntary hospitals for any discharge, any emergency room visit through the exchange, every single one of those transitions is going to get excluded. There's hardly going to be anything left at this point.

In other words, every transition between hospital and our core organization's primary care providers, we can query the hospital emergency room record and the hospital discharge summary, and they can query our record in terms of the last visits through the exchange now. That's been not only that, we get notifications through our system when there's new information. So, are you really suggesting that we're going to exclude that?

M

By the way, that's paramount. That's outside the context of the EHR. So, that might be one of the criteria, but we're ....

W

I guess my question is why wouldn't you just count those in the numerator. So, we don't really care how you go about transmitting, whether it's through send or a query, all of that counts in the numerator, but the denominator is still all transitions.

M

That's my understanding of what the NPRM currently would support as long as national standards or a nationally validated entity are used for that exchange.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Let me further—must this occur in the context of an EHR versus a separate parallel web?

M

Again, it has to be certified EHR technology, which could be a module, which could be HIE, could and some have gotten certified to readily, or it would be a Health Information Exchange Organization that's been validated to be a member of the Nationwide Health Information.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

It still has to be accessible to the EHR, correct?

W

So, the EHR is sent to the validated entity that counts?

M

So, the accessible is that in the messaging function I get a message that says click here to go out to the portal to get this information, or it actually says there's information on the portal, and then we've created a way to just click right from the record to get out to the portal. So, would that qualify?

M

If the intermediary that you're using to access information from the hospital has gotten certified to meet the standards, either the SOAP, SAML, or the direct protocols, or if they have been validated to the national standards.

W

But according to what this says it's saying it would qualify if it's an HIE but it doesn't qualify if it's –

M

My understanding of what the certification rule currently allows for in conjunction with the Meaningful Use rule is it's either certified EHR technology, which could include modules, which could include health information exchanges received to get certification. Or it could be a nationally validated entity which could also be a service provided by an EHR vendor.

W

But that's different than what it says here. Yes.

M

... the comments.

W

In the comment there it –

M

A comment from which group?

W

Information Exchange number two.

M

This is the current state of the NPRM, not the IE Workgroup recommendation.

W

What you just said.

M

What I just said, okay.

W

What they said is different than what you said, because they're saying it's okay if it's an HIE but it's not okay if it's another EHR, as I read it here.

M

I'm sorry. Farzad, are you looking at me? We were just tracking down the language, which we've found. George, do you want to –

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

This is under the 65% part. On page 111 of the original PDF, "If the provider to whom the referral is made or to whom the patient is transitioned has access to the medical record maintained by the referring provider, then the summary of care record would not need to be provided and that patient should not be included in the denominators of the measures of this objective."

Farzad Mostashari – Office of the National Coordinator– National Coordinator for Health Information Technology

Right, but that's a different scenario where it's the same electronic health record, not where there is a transaction that queries and retrieves the information from one electronic health record across an organizational boundary.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

I don't know if it's the same organization or you provided access to the EHR, so I don't know that it says that it has to be the same organization.

Farzad Mostashari – Office of the National Coordinator– National Coordinator for Health Information Technology

There's no transaction in that scenario.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Right, there's no transaction, but on the other hand it's just another form, whether it's a query transaction or we were just providing access, allowing a query is functionally equivalent to allowing access.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so we're trying to go down this path of figuring out where we agree. Denominator, it's all transitions or transitions for which there's no access to the EHR.

Farzad Mostashari – Office of the National Coordinator– National Coordinator for Health Information Technology

If I may, Paul?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes, go ahead.

Farzad Mostashari – Office of the National Coordinator– National Coordinator for Health Information Technology

It would be interesting to see, do people think that a query response should count in the numerator or not? If people think it should count in the numerator, then the denominator answers itself. Just to get a s sense of the group.

W

Yes.

M

I think it goes back to your answer to my question at the last meeting, which is we don't want to be really prescriptive about this. We're trying to get people to exchange information, and I think in that case you'd want to say yes, it should count. And as this evolves it may change, but right now it should count.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so let's go ahead, those in favor of that counting in the numerator and consequently the denominator raise your hand, please; 9. No? Abstained? Okay. So, one last point is the 10%, should 10% of these transmissions of this summary of care document occur as a threshold electronically? Christine?

Christine Bechtel – National Partnership for Women & Families – VP

I say yes, although I actually think the number, in my view, is too low given the data that CMS gave this morning on the percent of eligible hospitals and providers who are EPs, who are meaningful users, I think that in Stage 1 I think that this is actually too low.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Gayle?

Gayle Harrell – Florida – House of Representatives

I would disagree, in that it seems we don't know where those providers are that have attested. You don't know where there are holes and there are not people who are equipped to do this. So at this point, until more people are really meeting the threshold who have electronic health records, who are exchanging data are out there throughout the entire country I don't want to exclude people, so I think that 10% is very adequate.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

David Lansky?

David Lansky – Pacific Business Group on Health – President & CEO

To Christine's point, I would like to see a standard, which it may be too late in the game, where meaningful user to meaningful user exchange is virtually always electronic, 70%, 80% of meaningful user pairs, and since we do have a database now, that Farzad referenced, which is up and online and should be ... searchable it shouldn't be hard to execute it in real time.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Other comments? Okay, so here are two sentiments. One is –

Farzad Mostashari – Office of the National Coordinator– National Coordinator for Health Information Technology

(Inaudible.)

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Oh, sorry.

Farzad Mostashari – Office of the National Coordinator– National Coordinator for Health Information Technology

I was just going to comment that practically even ... I think 10% is a good number if you're having ... a little bit about where we are on this.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So a good number, meaning –

Farzad Mostashari – Office of the National Coordinator– National Coordinator for Health Information Technology

In other words, it's adequately high. I'd like to see a higher number, but it's just not trivial.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. One motion is to lower the 10%; another motion is to change the denominator to those, it's really meaningful user to meaningful user.

W

That's not what I heard. I heard everybody here say if it is the 10%, that's okay, not lower it necessarily. But then what David and I have talked about is make it 10% if it's MU/non-MU, but if it's MU/MU that we can recommend to the agency that they look at ways to increase that to be higher.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So those in favor of keeping it as written which is in the NPRM, which is 10% of all transitions occur electronically, so I think that's the default position here; 12, okay.

M

Thirteen.

W

No, but then also for investors ... I suspect, even though I voted for that because that's good, but then in addition to what we proposed previously would be meaningful user to meaningful user it is a higher percent, let's say, 50 for the sake of making a motion.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so this is a motion to add to meaningful use criteria.

W

Only for the Stage 2 of Information Exchange, I would just point out.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so let's see if there's support of ..., so all those in favor of adding an additional objective or criteria to this? Two.

W

I haven't had enough deliberation.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, good thought. We'll come back. All right, let's move on.

W

More on that one ...? I think one topic that you brought up in the very beginning which is interesting is it is care coordination, but there's nowhere that I have noticed, unless I missed it, where is it that if you're in an ED? And it's not a referral out, but an awful lot of the safety to patients is going to be who went with ED, they went to urgent care, if they were in trauma center, they live in two different places and they go to

their doctor in the other place, and even they work different than they live, shouldn't we be extending this beyond just as a referral?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

It's a referral or transition, so ED would be a transition. It would be a transition.

W

But I think – or maybe that was just under the workgroup one.

Farzad Mostashari – Office of the National Coordinator– National Coordinator for Health Information Technology

The question I think for measuring automated measurement of the denominator is how to count, and from a ... EH perspective we propose you count all the discharges, and from an EP perspective the proposal, I believe, is to look at transitions and one way to count transitions in the EP context is to look at referrals, for example. The question I think you're raising is if I'm an EP and I have a patient and they go to an emergency room, shouldn't that count as a transition –

W

If they pull the data, this is a query response, but pull it over –

Farzad Mostashari – Office of the National Coordinator– National Coordinator for Health Information Technology

So in that context you can count the numerator if you provided that information, but it's difficult to count the denominator of instances where that happened and a query did not occur.

W

Well, will the organization know how many times there was a paper referral that had to be faxed over? So isn't the denominator possible to count that way?

Farzad Mostashari – Office of the National Coordinator– National Coordinator for Health Information Technology

The presumption here is that there's a record of all referrals made, because those are ordered through the system, but emergency room visits that occurred that you did not get queried about, I don't know how one would measure the denominator –

Judy Faulkner – Epic Systems – Founder

Right, so all you're measuring is those ... and responded in paper, versus those measuring a response electronically. My guess is that if you're going to have it, it just says "transfers to another provider of care or refers their patient," so it's really missing the whole thing of a person shows up in the ED. Maybe the assumption, is, though, so you can do it that way, will it work the other way? But I do think that with interoperability where we have seen more people comment on the success of it is, and life saving, is in the ED than it is in referrals.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Wouldn't that come under different provider?

Farzad Mostashari – Office of the National Coordinator– National Coordinator for Health Information Technology

I think what Judy's pointing to is different use cases, and there's the planned care use case, which as Micky said was the focus of this, is care proactively coordinated, and then there's the unplanned use case and there have been lots of discussions on the Standards Committee in terms of the maturity and adoptability of the current standards and services around widely enabling and requiring nationwide ability to respond to these unplanned care requests, and something that we very much have on the timeline for Stage 3, but Stage 2 still focuses very much on the planned care.

Judy Faulkner – Epic Systems – Founder

I'm okay with that, because I think the technology is going to be similar and ... .

Farzad Mostashari – Office of the National Coordinator– National Coordinator for Health Information Technology

We hope that a lot of the building blocks will be in common.

Judy Faulkner – Epic Systems – Founder

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. It's future work. All right, let's move on. As you can all tell we're very short on time, so I'm going to try to combine some things. One, these next two have to do with what we have proposed in terms of the care team members and care goals and patient instructions, they've been subsumed under the summary of care and the workgroups agree. Any problem with that?

Okay, the next three, I'm also going to try to combine, and then Micky can help with this. It's really about population and public health, the goal is everyone wants to share this information, the goal is even everybody wants to have bidirectional exchange, and it's a how fast can we move by Stage 2. In essence, the Meaningful Use Workgroup is saying, if we're going to have to choose in public health, which is not covered by Meaningful Use, may not be able to concentrate on all three of these things, and if we're going to tackle these things immunization registries may be the top priority. So that's where we ended, George, right? Okay, so that's, in a nutshell, what we've said about the next three from the Meaningful Use Workgroup point of view. Micky, do you want to add to that, or George, did you have something else?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

(Inaudible.)

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And it's a clarification, we'll get –

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Sorry, it sounded like you had something. I guess in general our comments were related to providing greater specificity with respect to – there's a lot of local variation, as we know, in the public health infrastructure but we felt that reinforcing that variation was probably not a good thing, and that's what it felt that the NPRM was doing, so in general as a general comment we had some recommendations about trying to provide greater direction to some of that, recognizing that Meaningful Use doesn't cover the public health infrastructure. But that shouldn't reinforce that or even make that worse by entrenching it in there. Then we had some recommendations with respect to grandfathering some of the standards, and I don't know if you wanted to go into these details now or general public health and you want to go into the individual ones.

W

Just so you know, there's a part of the document that has recommendations for the standards, so those got moved down toward that part, if you're looking for them.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Okay.

W

And related to public health, your paper is different than what's projected, just so people aren't confused.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Which one's right?

W

They're both right. For the IE Workgroup I had said "see comment above," and then I just wrote the comments in for each one of them, just to make it a little bit clearer on what's projected.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Okay. It looks like, at least in the way that this is divided up then, it looks like that would be our main comment is really about providing greater specificity and there being too much optionality right now.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes, this has been a fairly challenging area actually. And the other comment that was brought up is despite the fact that "except where prohibited by law" was supposed to try to remove any, well, you can do it if it's not required and you don't have to do it, likewise, people brought up the fact that that might encourage people to pass laws that would get some people out of meaningful use. But anyway, I think the overall arching message, which Micky said, is it could deal with more specificity and almost prescription to help overall interoperability. Any other comments about this? I wish Art were here.

Okay, now the next couple of pieces have to do with registries. Again, the Meaningful Use Workgroup really echoes the desire, we've actually started in Stage 1 with the ... registries, the desires to move into areas where we can take advantage of these electronic systems, get aggregate data, and learn from them, yet continue to be stymied by a lack of standards even for commonly reported things like cancer, where there's still an abundance of methods and not one standard, and that's I think a lot what Micky will talk about.

So one approach we came up with in terms of a suggestion to this group is can we try to reinforce the goodness of registries by combining these two, cancer and other, cancer and specialist registry, into one registry requirement which would advance the signals, etc., advance the field and try to promote the creation of standards in registries, but not prescribing one such as cancer. So what's nice about cancer is it's very cross-cutting and very broad applicability, but there's actually still even a lack of standards.

The other concern raised that came up at our first hearing was that some registries have barriers, so it could be a cost barrier, it could be a proprietary data barrier, and it could be contractual obligations or a constraints barrier. All those things came up. Moving any one registry could actually be problematic, but yet we wanted to move the concept of registries, so our thought was to have a menu objective for registries, and to try to use that to move things forward.

That's the Meaningful Use Workgroup. Micky?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Yes, I think we had the same general concern, because we have some public health folks represented on the workgroup for the cancer registries that did have a specific recommendation related to CDC funded cancer registries, so it seemed that those could be specified. But with respect to the specialty registries we have the same general concern that there needed to be greater definition around it. We didn't go further by way of recommendation than just stating that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, comments, and please keep them short and to the point, moving towards some kind of recommendation. I think that expresses the general perplexed, stymied position we all have.

Farzad Mostashari – Office of the National Coordinator– National Coordinator for Health Information Technology

Question about this, what would the implication of this be for certification, that if they just could report to cancer registries they would meet the objective?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

The objectives, and this is probably addressed better by Micky, the objective is for the EHRs to be able to be compliant with standards as they emerge or contributing to registries. And of course that begs the

question, well, how is it going to happen? We're hoping that a menu requirement, even if, like in our past Stage 1 it's not widely subscribed to you, hopefully that would motivate both the registry folks and the EHR vendors and the standards folks to produce something so that we can, in the future, have common standards. That was the thought. Is it plausible to think that a single registry standard could be developed that would cover all the different types of registries? So are we going to develop standards for a cancer registry, for a diabetes registry, I mean, how would one go about developing standards like that?

M

I think there can be starts, to some extent. Just like immunizations and all immunizations the same. I don't want to answer each question, but that's –

Neil Calman – Institute for Family Health – President & Cofounder

So just a comment then, to me this seems like one of those things where one of the questions we've always asked ourselves is what do we need to push on that won't happen otherwise. So people are going to be using registries more and more, they're using them in quality improvement and other things like that, and I think in addition for those kinds of providers where submitting to registries is something that they do in the course of their work, like cancer registries and surgical things, they're going to look to their EHRs to be able to do that. Nobody's going to want to keep paying the clerks who abstract all of this stuff manually to do it once they're on an electronic health record. So I don't think we need to put a whole lot of effort into pushing this, because I think this is a natural evolution of where people are going. When the data's in there they're going to want to be able to get it out, to use it, to do the things that they're doing otherwise. I guess I'm least concerned about the types of providers where they're already submitting to registries on a regular basis because they're going to look to their EHRs to be able to do that. Nobody's going to want to maintain separate functions for that.

Farzad Mostashari – Office of the National Coordinator– National Coordinator for Health Information Technology

I think, Neil, one of the things we discuss in the NPRM is that there are particular groups of providers and specialists who are reporting to their registries, whether it's ophthalmology or gastroenterology or cardiology, who maybe should be getting credit that that's a meaningful use of their electronic health record. Maybe they don't interact with the immunization registries, but they do interact with their registry and that that is part of what they do, and quality improvement and so forth, as you're stating, and that that is a –

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

That is a credit for what you're already –

Farzad Mostashari – Office of the National Coordinator– National Coordinator for Health Information Technology

... credit on the optional side for things that they do in that respect. So that was part of the rationale of the NPRM.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

David Lansky?

David Lansky – Pacific Business Group on Health – President & CEO

Two things. One is, I think this, as Farzad is now saying, dovetails with what the specialty societies want to be doing to get – what's emerging is the desirability of taking a subset of what's in the registry from the EHR and then supplementing it with specialty specific content that isn't typically available in the EHR. So the more we can get the entire vendor community and the EHRs capable of populating registries with those commonly used items, that's a big win for all the specialists and it saves everybody a lot of money.

The second thing is, I'll mention coming up on the quality measures section, the vendors have been asking for some uniformity around value sets and to the extent these registries themselves are going to be accommodating common value sets to define essentially nationally standardized data elements for those specialties, there's a synergy here of getting general agreement about what populates the EHR and

then in turn can be multiply used by other purposes. So this is a stimulus, as you said, Paul, to a lot of virtuous change in both the vendor and the physician specialty societies.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so let me try to get consensus around two aspects. One is a menu registry objective, a single menu registry objective, and the purpose, again, is ... and stimulate what David and Farzad talked about.

The second then is whether we go further and either in the preamble talk about, let's say, CDC funded registries or make it a requirement. Okay? So one is a menu registry objective, a single menu directory objective, for the reasons that we talked about. Is there support for that? Okay. Second is, do we endorse, approve, what is the level of talking about specific government funded registries that exist already, for example, the CDC and NCI? Is it a preamble, kind of here are some examples, or is it a requirement? Examples. Head nods around examples, okay. Okay, so we can include some of that language in the preamble. ... .

David Lansky – Pacific Business Group on Health – President & CEO

My understanding is that important to cancer registries is required in many states, so I don't know if that changes it at all, including the preamble may then cover it if it's already required by the state.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, probably not through EHRs, though, maybe out to their separate ... . Okay, now I think we're finishing with the privacy and security, which is really HIPAA and the addition is the encryption of data at rest. Anything further you want to say?

W

Yes, I think the only thing I'll say is that essentially they adopted the recommendations which we had made, and so we didn't have anything to add other than it's always helpful to pat them on the back when we like what they're doing and we should say that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so noted. Okay, thank you. We're behind, so every time we use up more time we're taking away time from somebody else.

W

You said that really fast.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so we're now on to page 30, which is clinical quality measure comments. Am I correct, Michelle, is that where we're – okay. David Lansky, take it away.

David Lansky – Pacific Business Group on Health – President & CEO

I want to hand out a supplementary page which I'll refer to in a minute, but I'll send it around now so you can eyeball it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

You're adding to our 40 pages?

David Lansky – Pacific Business Group on Health – President & CEO

Well, the Quality Measures Workgroup has asked that you all receive a copy of this and consider whether you wish to include it in your recommendations. So let me make a general comment. The Quality Measures Workgroup has been meeting a number of times over the last couple of months to discuss these comments, and I would say what you have in front of you as comments is the best distillation we could put together of their conversation so far, but there are at least two major items that are not in here and the committee would like me to bring that to your attention for possible comments for us to include in the Policy Committee's letter. Let me set that up a little bit and then we can go through these individual comments.

What we have in front of us are some individual comments pertinent to the proposed rule, but I think what has emerged from the last couple of months is a recognition that the Quality Measures section of the Meaningful Use EHR incentive program needs continued evolution. It's not just a matter of tweaking some thresholds and adding some bullet points, a lot of what we've just done over the last couple of hours and the functional criteria, but it's really structurally not quite where it needs to get to be most effective. I think part of what we want to bring to you is a request that this committee make a couple of comments to CMS about what needs to happen, both in Stage 2 and in Stage 3, to get it closer to where we think it could be. And then it's really important that CMS and ONC take some firm steps now. If we're going to be there by Stage 3 we have to take bolder action now than we have been taking to date to get the quality measures approach right, and the NPRM is currently in front of us and doesn't quite do what we think it needs to do. So what I'll do is go through the specific elements here in the comments in front of us today, and then add two considerations for you. One is that we contemplate using the meaningful use program as a place to test measures that are close to ready, rather than redeployed measures that are already well understood, and I'll come to why that's being proposed by a number of constituencies.

Secondly, that we consider the page you just got on the Vendor Tiger Team as a suggested set of infrastructure activities that we would encourage CMS to undertake in the next year or two. So I'll come back to those two suggestions after we go through the specific comments in front of you, and hopefully these won't be too controversial, but we'll see.

Going back to page 30 of the packet, the Quality Measures Workgroup Comments, you see a preamble there that we basically endorse the strategy in the NPRM for Stage 2, we have a concern about the care coordination measures being inadequate. And I would say more broadly that in general CMS made a good attempt to classify all of the 125 measures plus into various buckets, but it's a little bit of a stretch and the reality is we don't have very good measures in many of those domains, we talked about that at some length last month at this meeting. Nonetheless, our note is there's something to address the measure concepts for each constituency, but we're pretty weak, especially in care coordination.

You see some specific comments about specific measures, falls, risk screening, med rec, ADE prevention, HART, so those four recommendations are in front of you of suggested comments from the committee for relatively technical suggestions about improving those measures, and we welcome any comments from you all of course on that.

The last item on page 30 that the quality measures set should include more on patient experience, and we've seen today in a couple of areas where measuring patient experience is a good way to get at whether these functions are actually being effective. We do have a real serious problem of connecting data from the patient experience survey world to the EHR world, and that's still an unresolved platform connection methodology problem, and again, without some really concerted effort it's not going to be available by Stage 3.

Let me just stop there, before we turn the page, and see if on the comments on page 30, most of which we had mentioned to you at the last meeting, people have additional comments or questions today before you consider them for the Policy Committee.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

... discussion, it's basically pointing out some areas where the current measure set is weak and for new ones to be ... . Larry?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Larry Wolf. On the patient experience, so most of the patient satisfaction surveys are done anonymous and so it's a structural issue of the data's not there to tie together. I don't see how to bridge that other than perhaps including voluntary feedback as part of here are questions for the patient to answer in the care setting.

David Lansky – Pacific Business Group on Health – President & CEO

I would say obviously today we can't get into the options, but I think the basic premise is the quality measure of whether a provider, an EP or a hospital, has been deploying HIT in a way to improve care

coordination, etc., etc., that active measurement wouldn't need to compromise the anonymity of the patient. It would of course ... attributed to a doctor or attributed to a hospital, but there is a methodology issue that I agree that we haven't resolved it, but we feel as a committee we'd like to move that agenda ahead.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Thank you.

David Lansky – Pacific Business Group on Health – President & CEO

On page 31 the group reporting option, we discussed this again last time, and there was some concern that group may not be a meaningful collection of doctors who are actually sharing practice style or achieving common goals or for whom the quality measures make sense as applied to a group. We don't have a solution to that but, as you see here, we suggest that CMS do a little more refinement of what constitutes the purposes of group reporting.

Farzad Mostashari – Office of the National Coordinator– National Coordinator for Health Information Technology

Just a clarification question, this is group reporting, I don't have page ... on the proposed rule in front of me, but this is group reporting for quality measures, or for functional measures?

David Lansky – Pacific Business Group on Health – President & CEO

This is for quality measures, which is our purview, yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And you point out there's really two kinds of groups, those who really are working together, okay, thank you.

David Lansky – Pacific Business Group on Health – President & CEO

On page 32, on the EP reporting options this is a much more fraught area. The proposed rule had option one and option two. Option one had parts 1A and 1B. Proposal 1A would provide a very long list of quality measures, and each EP would pick 12. Option 1B, there would be a short list of 12 quality measures from which EPs would pick 11 and then pick one from the long list. We had recommended previously that option 1A be the primary means for reporting for individual eligible professionals, and option 1B be considered for group reporting as a place, especially groups that actually practice primarily primary care. As we noted today, one of the ... reports that 57% of the Medicare meaningful uses are specialists and so it may be difficult for specialists to find themselves very effectively on that short list of 12 measures, the core measures. So let me just turn for a second to, well, let me go through the rest of this. The note on here that proposes allowing EPs to report 6 measures instead of 12 was actually not a consensus recommendation from the Quality Measures Workgroup. It was a suggestion and essentially the suggestion is to consider a lower number of required measures. That did not have uniform support within the Quality Measures Workgroup, but I'll bring it to you as a consideration, and you see the reasons for that listed below.

I'd say the additional option I want to put in front of you for considering, which we call option three, which was not on the ... is again this concept of using the meaningful use program as a way to test measures that are in development. And essentially our notion is that we should allow a pathway that if an EP can say I propose to submit the following six measures which cover all of the bases in the different domains, efficiency, care coordination, patient engagement, and so on, and has been certified by NQF or a similar body through a preliminary approval process, which NQF is setting up, is good enough for widespread testing. That would be a way to allow specialty societies, various groups of physicians to say here are six measures that are high value that we really care about that have met a set of criteria and we would like to generate them from our EHR and produce them for quality reporting, uniformly because they've been approved by NQF, they've been approved by our specialty society, or some other body, and it's meaningful to us as ophthalmologists or gastroenterologists or whatever it is. That would be a pathway to generate the measures we're all frustrated we don't have, high relevance to quality improvement and practice documentation for those providers, and accelerate this process, which right now a lot of us are

very concerned that we have a stalemate of quality measures development process that's not getting us the measures we need.

One other factor I'll mention, which is in the note you just got from the vendor group is a sense that the attempt to retrofit, to reverse engineer old measures into the EHR environment, has essentially failed, and the reasons for that we don't have to get into today. But the proposal to correct that is to allow a little more proliferation, that because the meaningful use measures are not tied to high stakes payment, performance doesn't matter, there's nobody looking at your performance, there's no publication of these data to anybody, this is a great environment to accelerate use of high relevance, high value measures that the providers themselves think are invaluable, but also meet our criteria and the criteria of the national quality strategy. That's option three that I hope we can at least briefly consider whether this group is comfortable encouraging CMS to consider doing that.

Let me go on to the last item here, PQRS reporting on this page, which was actually the option two of the proposed rule. Our concern here, which is a generally felt concern, is that it would not be appropriate to allow someone who submits PQRS measures to get credit for meaningful use, but that the reverse would be valuable. If you submit meaningful use criteria you should get credit for PQRS. And that's up to CMS to evaluate whether that makes sense. But we are concerned that the other way isn't appropriate. We are not convinced that meeting the PQRS reporting requirements does make you a meaningful user, even though the data may come from EHR. So we would propose that CMS reverse that language.

The last thing on my report I guess is this page you have from the vendor group, and let me just explain where that came from. We had heard a number of concerns from vendors that the experience in Stage 1 has been very difficult and expensive. They anticipate that the NPRM's requirements for quality measure production from the EHR as CMS initially proposed it would be very expensive and burdensome and of uncertain value, so we had a good meeting with the vendors to discuss their experience working with their customers and of course the technology issues about producing quality measures, and it creates, for me at least, and a number of the staff at ONC, some real insight. And that's reflected in the summary page, which is not by any means the last word, but it gives you a directional sense of what we're hearing, that there are some things that we collectively could be doing to improve the measurement generating capability of the EHR which is outside of the context of the technology.

One of their suggestions, as you saw, was that we develop some national understanding of value sets, that we constrain the production of quality measures to those value sets for fixed periods of time, so that for two years or whatever it is everybody knows this is the knowledge base we are building from for our quality measures and if we were to do that the vendors feel they could be more flexible and adaptive in producing query tools and reporting tools and analytic tools from a known set of data fields and value sets.

I think that's a very constructive dialogue. We're not at the end of it, but I think that's the pathway that's been suggested. If that made sense to this group we might make a recommendation consistent with this short memo that encourages CMS and ONC to work together to develop that kind of a platform over the next year or so, whether it's through the IOM or through some other independent vehicle to get that work done. That would probably help us all solve the problem we've talked about many times of having a better platform for quality measures reporting and use.

So let me stop there. I know it's a lot to throw at you late in the day, but, Paul, I'll let you think about how to handle that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, there it is. Okay, let me try to divide them into individual recommendations. So first is the 1A, 1B and option three. I think what I heard was 1A for PCPs; 1B, was it optional for specialists, or just make it for specialists?

David Lansky – Pacific Business Group on Health – President & CEO

Well, CMS initially asked us to pick one essentially, and our answer is both, but let 1A be more germane to EPs and 1B for group reporting.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay.

W

For group reporting or specialists?

David Lansky – Pacific Business Group on Health – President & CEO

Group reporting.

W

Group reporting, right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

It would be for group reporting, yes, okay. So let's take that up first, how do people feel that selection is 1A for PCPs?

David Lansky – Pacific Business Group on Health – President & CEO

1A for any EP.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Sorry, 1A for any EP.

M

I just have a question. The concept of value sets is new?

David Lansky – Pacific Business Group on Health – President & CEO

I don't know that it's new.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Let's go to that one and when we get to that point we'll discuss it. So 1A for EP, does anybody have a problem with that one? Yes?

W

No problem.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

No problem, okay, fine; 1B for group reporting, and that's the pick 6 or 12, pick 11 core and then 1 –

David Lansky – Pacific Business Group on Health – President & CEO

We proposed 11 in core and –

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes, 11 in core and then 1 from menu.

Farzad Mostashari – Office of the National Coordinator– National Coordinator for Health Information Technology

Just a point of clarification perhaps, one of the things we made clear in the NPRM is that the total number of measures including potentially many of those in that listed set of 12 core, we expected that to be reduced based on the comments received and also in terms of the timing of whether testing would have been completed or validation in ... specification would have been completed on those measures. So not only would the 125 potentially be reduced, but also among the 12 or so that were listed there, the 11 core that were listed there, presumably through the natural process of this, that many of those 11 core may not be in the final set, so I think a lot of people were puzzled, like 11 out of 12, how much choice does that give you? But the 11 core may, just as a natural process of the comments and the measure development, go down to a smaller set.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. Another recommendation from the group is so-called option three, which is to allow for use of, and I believe you said NQF endorsed?

David Lansky – Pacific Business Group on Health – President & CEO

This presumes that NQF would generate a new label, a preliminary endorsement, not a final endorsement.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Not final tested, okay. So the idea here is a route to get faster delivery of probably de novo EHR sensitive measures and one of the challenges of getting NQF endorsed is testing, so this is even a route to testing, and so the proposal is would this be acceptable to CMS as a quality measure for the quality measure requirement? Discussion or support of that? It looks like there's support of that.

Okay, the third topic is the PQRS, the chicken and egg. It's the feeling of the workgroup that the meaningful use being deemed for PQRS makes a whole lot more sense than PQRS saying you are essentially deemed a meaningful user. So it's to reverse that deeming, and it looks like there's pretty widespread agreement with that one.

Okay, and the fourth one was, wait, you'll have to state it for me again, David.

David Lansky – Pacific Business Group on Health – President & CEO

Regarding the standard Tiger Team recommendation to encourage CMS and ONC to pursue supporting the infrastructure for de novo measure development along these lines, for lack of a better word.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

It seems like that could be outside the context of response to the NPRM. It's something we've been very interested in and we've even had both hearings and presenting, and we might flesh this out. In fact, you're working with this group more, so we might come back with that in a more fleshed out scale for endorsement by this group and out of the context of the NPRM process.

Farzad Mostashari – Office of the National Coordinator– National Coordinator for Health Information Technology

Are you saying that in the context of the 125 measures that there are the de novo measures and there are the re-tooled – are you talking about that? Are you talking about the –

David Lansky – Pacific Business Group on Health – President & CEO

No.

Farzad Mostashari – Office of the National Coordinator– National Coordinator for Health Information Technology

... a go forward process of creating and enabling –

David Lansky – Pacific Business Group on Health – President & CEO

I think from our point of view, Paul, to your point, where it fits I don't know, either in the comments themselves or in the cover letter, indicating to CMS that the Policy Committee feels strongly that to get this ship on the right course some of these things need to be addressed promptly, so that I don't think it has ... an immediate impact on the Stage 2 measures. I don't think.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think as much as we'd like to it's probably not in the cards from a timing point of view, but how are ways, including this forum, we're saying this is really important and we would like to have a more fleshed out recommendation, because I think that's the secret one, I think. And we can come back and deliberate and come out with a ... HITPC letter about this. Does it sound fair? Okay, very good. So that concludes the Quality Measures Workgroup's comments. Okay. Now we're going on to some comments. Michelle, is this the section where you think we've covered all of these?

Michelle Nelson

Thinking about time, we may want to come back to these after we do the next section.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Correct. Okay, so the next section starts on – we're checking.

Michelle Nelson

Thirty-six.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Thirty-six?

Michelle Nelson

I think it's 36, yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. Because we already covered the other comments before this group and there weren't any push back comments. Okay, 36, 37, yes, I think we've done 36. Okay, privacy and security.

Michelle Nelson

These are another handful of recommendations that the Policy Committee had previously made that in fact were included in the rules and so this is, again, another underscore of please include them. I thought we did this already, but that's okay. It deals with both the risk assessment as well as the capability to amend patient's health data and also in the view, download, and transmit capability, which we sometimes call the portal, we get in trouble for that sometimes, the ability to have a patient accessible log. Again, all of this is all included and so we're just saying bravo, please keep it in.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Thank you. Okay, Micky, this next one has to do with IE Workgroup, and you might want to explain –

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Are we on page 38?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes, we're on page 38, correct.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Okay. Yes, I was just trying to disentangle the way this was divided. We had a general one that's actually back on 24 that I did that I think didn't get covered, which was the definition of successful ongoing submissions. So we had a specific proposal related to how to define that reflecting, I think, both our concern and the Meaningful Use Workgroup concern about no definition related to that, so that's back on 24, and I'm sorry, I should have mentioned it before, but in the way that ... I couldn't tell whether it was in the earlier part or the latter part. The reason I mention that is because if you look at the first paragraph on 36 it gives greater perspective on this idea of successful ongoing submission and provides a little bit of context and some caveats about what might be some difficulties in measuring successful ongoing transmission, I think is the term of Art's that's being used. So there are specific recommendations on page 24, which is about defining it to be 10% of all qualifying transactions, and again one of these stage things, so increasing ten percentage points per year to a maximum of 50%, just a proposal rather than leaving it open ... ongoing.

And then we have some specific recommendations related to specifying transport requirements, and now I'm on page 38, and for public health transactions that are aligned with the transport requirements specified for transition of care summaries, like grandfathering the existing transport that's ongoing right now with public health, so that's the first bullet, and again this got cut up in a different way, but the first

bullet, the last part of it says specify transporter requirements for public health transactions aligned with transporter requirements. So that's one recommendation.

The second is supporting the single standard from public health transactions, but recommending a grandfathering for those EPs and EHs who met a certain set of conditions. One is that they implemented 2.3.1 to achieve the Stage 1 objective. They went beyond a single test and maintained submission to public health during Stage 1, and are reporting to a public health department that is discussing 2.3.1 and they're utilizing the same EHR technology. So basically in Stage 1 we allowed 2.3.1 or 2.5.1 and now the recommendation is to convert to 2.5.1. The recommendation is to grandfather those who in good faith implemented 2.3.1 and are continuing to do it, and they're using the same technology. And the concern, while some may say well, there's not that big a difference, the concern that we had is that vendors may charge providers for switching from 2.3.1 to 2.5.1 and that's a burden on providers who were really doing the right thing and are continuing to do the right thing. So this wouldn't apply to those who just did a single test. It wouldn't apply to those who change their EHRs. It's really about they did it in Stage 1 and they continued to do it according to the guidance that was provided to them, and we don't want them to be penalized for that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think the second issue you raised is more a standards certification point. The first one, is that something that this group needs to take a position on?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

I don't know. Again, the question, is that a policy or a standard issue to say that the policy ought to be that there ought to be transport requirements for public health transactions, just as we're recommending for transition of care summaries, and then it also says that you should grandfather the existing transport. So I guess that's up to this group to decide whether that's a policy question or a standards question.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think it's standards. I think it's standards, yes. Okay, it seems like a reasonable way of handling it. Anything further you need from us on this one?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

No.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, then we're moving on to privacy and security with EHR modules.

Deven McGraw – Center for Democracy & Technology – Director

All of these comments are related to standards now.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay.

Deven McGraw – Center for Democracy & Technology – Director

Well, they're related to certification, right, yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And so is this privacy thing a policy issue that –

Deven McGraw – Center for Democracy & Technology – Director

Again, we didn't touch anything that the Policy Committee hadn't already opined on in previous recommendations. And so they were not specific to technical standards which we let the Standards Committee handle, but rather what are the capabilities that need to be in certified EHRs from a privacy and security standpoint. So essentially what we did was to asses those. EHR modules is the first one and I'm asking Paul to walk us through that, but it's also the one that's likely to generate the most amountof conversation. So I'm wondering if we could, I'm on page 40, I'm wondering if I could

summarize what else is on this page because we might actually be able to, I'm hoping, sweep it all through. Skipping EHR modules, again, I'm on page 40, and going to patient portals, we have previously recommended that there be functionality in EHRs for the portal function and that patients be authenticated at least through single factor and that there be the capability for secure download as part of certification, which wasn't expressly stated in the NPRM.

So essentially what we're recommending here, and we tried to bold the text where we actually say something that looks like a recommendation, is that we recommend that ONC clarify in the, well, it says in the NPRM, so it would be in the final rule, that in fact the requirement to authenticate users of an EHR would also extend to patients who would be using VDT functionalities. Similarly, we thought, yes, you didn't say specifically authentication and secure download as part of certification. If you don't want to include those in certification we think it's important that the Office for Civil Rights actually gives some guidance. We think the security rule essentially requires providers to have security functionalities in the portals. So if these aren't going to be tested necessarily expressly as part of certification there ought to be some guidance that should go out to providers who are rolling this out about what they ought to be doing from a security rule compliance standpoint. So that is what we recommend for that piece.

In terms of data provenance, I'm already on page 41, with, again, this is all with respect to portals. Clearly there is provenance data in the CCDA that patients will be able to access through their portals, but we think that patients should be able to view that, whether it's obvious on its face or it's easy for them to find, I think we didn't necessarily focus on. And then we had previously done a lot in this group on guidance to providers, and vendors quite frankly, about being transparent with patients about the risks and benefits of the portal, and it didn't get very much play in the NPRMs, in part because we didn't ask for it to be part of certification, so it's missing from the conversation and so we're just using this as an opportunity to say don't forget about the guidance. It's important that patients be aware of what they're doing here.

On the amendments piece, again, we did get some of our recommendations endorsed in the NPRM, including the capability of being able to amend data and to have data appended when there's a dispute, which is already required from a policy standpoint in HIPAA but the EHR technology should support that. There was a specific question that ONC asked about formats that the appended data should be in, and we basically said both formats that you offer, you should do that, and we had received a public comment about being able to append images that are supplied by the patient and so we included that as well. And we wanted a signal that in Stage 3 these amendments should be able to be transmitted, so that when providers know and feel that they need to tell other people about a correction to data they have the capability to do that, that was a recommendation we made previously that didn't get included. On the issue of digital certificates, it's clear that the validation aspects of authentication we think, well, maybe I shouldn't say, we think that the validation aspects of authentication are covered in the transport standards, but the high level of assurance that we asked for we're hoping will be in the NwHIN governance rule, and we'll soon find that out, at least whether you want more information on that maybe we'll include it on that too.

On patient matching we had some specific recommendations with respect to demographic data fields and standardization and the testing of those data fields in order to ensure that patient matching can occur. So essentially we continue to recommend that EHRs be tested and certified for the capability to correctly populate standardized demographic data fields for outgoing patient data and then the capability to make incoming data readable and available to assist in the process of matching. And as to the question of whether the EHRs should themselves be certified to do automatic matching, our sense, and we reached out to some of the entities that had testified to us on the patient matching hearing about their thoughts on this, and three out of four of them said EHRs aren't ready to do this necessarily, although there are technologies that are available to do this, so that might be something that you could look to including in the future.

Then the last thing we said about matching was the issue of USPS normalization, which was one of our recommendations. We said it should at least be recommended as a best practice. Other than leaving HR modules out, which I'm going to ask for Paul to help us on because it's a tough one, did I leave anything out, Paul, any other –

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I can't imagine you left anything out. That was incredible.

Deven McGraw – Center for Democracy & Technology – Director

It was a lot of stuff. It was a lot of stuff. There's a tremendous amount of work put in by the group on these issues, but we really did try to focus very specifically on what had we collectively said as a Policy Committee before, what did or did not get adopted in certification, and what did we feel needed that we would reemphasize or push or say, well, if you're not going to do it this way then let's have some guidance as an option.

Farzad Mostashari – Office of the National Coordinator– National Coordinator for Health Information Technology

That was tremendous, Deven, and high velocity.

Deven McGraw – Center for Democracy & Technology – Director

Sorry. I'm trying to preserve everybody's time.

Farzad Mostashari – Office of the National Coordinator– National Coordinator for Health Information Technology

Let me ask for a couple of clarifications.

Deven McGraw – Center for Democracy & Technology – Director

Sure.

Farzad Mostashari – Office of the National Coordinator– National Coordinator for Health Information Technology

The first, were you talking in terms of the view, download, and transmit, that mobile and other means of accessing that information count towards the – you were saying something about the portal and that there could be other forms that should be accepted. Is that what you're –

Deven McGraw – Center for Democracy & Technology – Director

No.

Farzad Mostashari – Office of the National Coordinator– National Coordinator for Health Information Technology

... getting at? It's just someone has an iPhone app that lets them access the patient portal, that that should – that's not what you're talking about?

Deven McGraw – Center for Democracy & Technology – Director

No. We were specifically talking about the basic security functionalities around a portal, like authenticating patients through, and I know our previous recommendations, but at least single factor and that the download and transmission be through secure functionality. And essentially what ONC said in the NPRM is, well that's so ubiquitous that I don't think we need to require it for certification.

Farzad Mostashari – Office of the National Coordinator– National Coordinator for Health Information Technology

Yes, because I guess they have to –

Deven McGraw – Center for Democracy & Technology – Director

Yes.

Farzad Mostashari – Office of the National Coordinator– National Coordinator for Health Information Technology

And the other clarification, we asked in the section around information reconciliation in the requirement around being able to integrate information we asked about whether there should be a requirement in

certification around providing patient reconciliation so that you're sure you have the right patient probably before in the workflow that you actually integrate that information. Is that the section that you're talking to, and talking about automated matching?

Deven McGraw – Center for Democracy & Technology – Director

Yes.

Farzad Mostashari – Office of the National Coordinator– National Coordinator for Health Information Technology

Because I don't think we actually said automated matching. I think what we were asking about was not the automation of the matching, the question was whether the health record just as it might assist you in matching mediations or diagnoses, reconciling those, we were asking about whether the tools should be certified to information, a patient reconciliation. I don't think we said automated but –

Deven McGraw – Center for Democracy & Technology – Director

So that may be my own shorthand. But I can tell you that we, verbatim, pulled the text from out of the NPRM when we sent the question to four of the entities that had testified at our patient matching hearing, and I think all of them interpreted it to mean some sort of machine functionality of matching that to us seemed automatic based on data coming in versus data in the record and reconciling it without the need for human intervention, I think was essentially interpreted, but I asked actually for that information to also be passed along.

Farzad Mostashari – Office of the National Coordinator– National Coordinator for Health Information Technology

Okay, so it would be helpful if your comments included, aside from the automated machine operated matching issues whether there should also be, separately if you could comment on the generic functionality to have identity reconciliation as a part of information reconciliation, however the tool does that, but to basically say this is the information you have on the patient, this is the information demographic and other information on the patient coming in, are you sure it's the right person before you start forging the data in –

Deven McGraw – Center for Democracy & Technology – Director

Okay. I definitely feel as though based on the conversations that we had, something that would flag a capability to say, here's two records but would require a human to say, "Are they the same records?" would be consistent with what the Tiger Team was envisioning. I know we have plenty of folks around to keep me honest on this one. Thanks.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Judy?

Judy Faulkner – Epic Systems – Founder

One thing I've seen some of our customers be concerned about is if there is a patient matching and the patient, they decide by looking that it isn't the right matching, and they then have to report it as a PHI violation. I've actually seen that. Any comments on that?

Deven McGraw – Center for Democracy & Technology – Director

There are exceptions to the breach notification rule that as long as you don't do anything else with that data and just essentially report it back to the facility that sent it to you, I would conclude do not equal breach.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Is the term "incidental disclosure" or something like that?

Deven McGraw – Center for Democracy & Technology – Director

There's an incidental disclosure provision under HIPAA and then there's a specific exception for when it goes to another healthcare provider and the provider says, oh, wrong patient, and sends it back.

W

Paul, this isn't California.

Deven McGraw – Center for Democracy & Technology – Director

Well, they have their own state laws to deal with. But in terms of HIPAA I would argue that there's plenty of exceptions in addition to that harm standard, which as of today still exists.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, do we want to close this off, or do you want to include Paul's talk about the EHR modules?

M

I want to jump in with a sequencing question. So we skipped over page 39, which had the comments from the Certification Adoption Workgroup –

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

No, no, no, we'll go back. We're still finishing up with the –

M

We're on page 40.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I understand. Somehow we –

W

(Inaudible.)

Deven McGraw – Center for Democracy & Technology – Director

Whatever you think is best, Paul. I didn't sense any discomfort on the pieces that I did, and I did the easy ones along with the hard ones.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So we'll go ahead with Paul then. Just don't mess it up, Paul.

Paul Egerman – Software Entrepreneur

I feel under intense pressure right now. That's okay. The transcript will just say, "Paul said" and we'll be okay. On the issue of EHR modules, what it says in the NPRM preamble was that what was done in Stage 1 was to test each module for security, and it created a whole series of difficulties for vendors, and that way vendors would have to redesign their systems just so they could pass certification as opposed to improving security, but just be able to pass the certification process. So what's in Stage 2 is to say you no longer have to have security testing of the EHR modules. You still have to have a system, though, that meets all the security requirements and all the legal requirements, it's just that security is not going to be tested for each module. And then when we had discussions within the workgroup this was a hot topic, because some people were very concerned about what appeared to be a reduction in terms of testing for security, and a number of alternatives were suggested. However, there was no consensus around any of the alternatives and so we don't really have a proposal to put forward to you to say here's what we want as an alternative. So my own comment about it is this is helpful and it's something that sometimes happens to the whole security world, where with good intentions you put forward something that you think is going to work and when you go to implement it, it doesn't work right. So you have to take a step backward from it, which is ... in Stage 2.

Deven McGraw – Center for Democracy & Technology – Director

I would say the only thing, the reason why I labeled it as tough is because we did have an opportunity to query the Policy Committee about this last month, and not surprisingly there were concerns raised about the fact that there would be modules without necessarily being tested for the security functionalities but speaking about how you would resolve that when you're talking about modules that don't necessarily have to be tested together and you do have the requirement for the base EHR to have those functionalities, what would we really recommend on that score? And the Health IT Standards Privacy and Security Workgroup has put a recommendation forward that their Standards Committee adopted that addresses this more technically, but it's not one that we could necessarily coalesce around. So we're at the point where I think with more time we'd see if we could tease out something that we might be able to get consensus on, but personally I'm with Paul, I think this is one where a number of us are concerned about this, but we don't have a good solution about how it would get resolved that wouldn't be true to the certification program, which is about allowing people to put things together themselves from modules if they choose to do so. I guess our recommendation would really be that we're silent on it but we have concerns raised in this matrix that reflect both sides.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

The new norm, is that anybody a base EHR or better would have security requirements, but modules by themselves don't.

M

They're not tested for them.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

They're not tested for them.

M

That's not to say that they don't have security, but they're just not tested for them.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right. Okay ... important distinction.

Paul Egerman – Software Entrepreneur

It is an important distinction because the observation that was made is the purchasers of systems who purchased it based on modules tend to be more sophisticated purchasers, they have IT departments, and they are probably capable of making their own assessments, and it's a standard thing. When you do this it's to figure this all out. Is this going to work with my security ... purchase this module?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And all these folks are covered entities and they're still covered by HIPAA to this day.

Paul Egerman – Software Entrepreneur

That's correct.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And those in California –

M

(Inaudible.)

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And we live in a different world that's more restrictive. Larry?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

I'll bring it up later.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, great.

M

We love the state of California.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

We love the state of California.

W

Can I just make a comment about volume? I was talking to someone yesterday who is a CIO of an organization that's putting in an enterprise wide system, and they have 250 modules that they're connecting with, and my guess is that if you have a different approach of multiple niche modules you might be talking about 1,000 different ones, and it was just an interesting, if you're a large, multi-site organization just an interesting thought as we think about their work.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, are people comfortable with the comments of the Privacy and Security Tiger Team and the lack of a conclusion and really just a commentary on EHR modules? ... go. My page 39, I must be on a different version. Oh, okay. Christine –

Christine Bechtel – National Partnership for Women & Families – VP

I have a process question, if I may, because I have a hard stop at 3:00.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes, I think we're trying to do that.

Christine Bechtel – National Partnership for Women & Families – VP

I know. But there's a lot in here, Larry, that I just don't understand enough to know what we mean. There's also just, frankly, not enough text in here to get it, and I don't know that we have time to go through it, so I'm not sure how to handle that, because there are a couple of things that on a first read I don't think I agree with or are comfortable with, but I don't know that we have enough time to discuss. So I don't know if there's a way for a letter to go forward from the workgroup but not through the Policy Committee. I don't know what to do here given our time limitations.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

All I can say is that we originally expected an hour of discussion.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, which would make sense.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, do you want to take on a couple of high priority areas, and then I guess what we have to do is resort to a phone call to pick up the rest. We're all in this together, so what are some of the high –

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Let me toss out the first two as potentially actually needing discussion, since they came in and didn't get that much discussion within the workgroup but seemed like they're important for discussion, which is specifically there is no integration testing, so even when we say base EHR, those elements are not tested together. So even though there's a security and privacy requirement in that piece, there still could be integration questions. And everyone knows it's very complicated, especially if you start to allow any to any, so the thought was is there value in allowing voluntary, some kind of voluntary integration testing, so

where a vendor has all the pieces that make up a base that they could in fact be tested together and there would be some way of actually stating that they were integrated. Right now there's no integration statements anywhere, so the question is, can we pursue a way to move forward the discussion about modules needing to fit together.

Farzad Mostashari – Office of the National Coordinator– National Coordinator for Health Information Technology

I think that pre-coordination in coming in to seek a single certification ID for either a complete EHR or for certain modules that come in together and receive one certification number is already enabled in the program and would be enabled under the permanent program ... .

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So use the fact that there's a single, they would test it together.

Farzad Mostashari – Office of the National Coordinator– National Coordinator for Health Information Technology

Together.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Okay, so I guess this maybe gets to some of the – so if you could get the pieces working together that would be great. There really is no integrated workflow testing that happens today.

Farzad Mostashari – Office of the National Coordinator– National Coordinator for Health Information Technology

That can be a recommendation that the testing should be integrated and in the certification testing, which isn't addressed in the certification criteria themselves, but certainly this group and the certification group has talked previously about having scenario based or script that your entry of one thing then is tested in the next portion of the test. So stringing together those, that could certainly be --

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Okay, so I think that would be then probably consistent with the limited conversation we've had on this piece. What other highlights to pull out here?

W

In other words, it's not a voluntary certification aspect, but more the approach that is already being taken to certification that would allow that?

Farzad Mostashari – Office of the National Coordinator– National Coordinator for Health Information Technology

The first point that was raised in terms of being able to bring a set of modules together to be certified together, that is already ... .

W

That already exists, yes, okay.

Farzad Mostashari – Office of the National Coordinator– National Coordinator for Health Information Technology

The second point about having the testing scripts enabled more of a test of the integration between the different modules is a separate, I think, comment.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Maybe I should let Christine highlight the ones that you felt like these are hot buttons and we should make sure that we get a real discussion.

Christine Bechtel – National Partnership for Women & Families – VP

Paul said ... so I packed up.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Okay. Sorry.

Christine Bechtel – National Partnership for Women & Families – VP

... I'll tell you. One is the price transparency piece, I just don't understand it. One is the Info button piece. One is –

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Price transparency, we can talk about. Price transparency I think was pretty easy, or hard.

Christine Bechtel – National Partnership for Women & Families – VP

If you flip to the next page it's right above the Privacy and Security Tiger Team.

W

Oh, okay.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

We basically felt that pricing is a pretty complicated area, that trying to put a single dollar amount was not going to communicate anything of any real value, that to a provider organization they could easily spend way more money on implementation, training, workflow redesign, than they did on their software. And it might be worse than no pricing information in terms of misleading on what it's going to cost them to buy and make something usable.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So are people comfortable with that recommendation that then ... .

Farzad Mostashari – Office of the National Coordinator– National Coordinator for Health Information Technology

I just want to clarify what the certification part of this addresses obviously is not the implementation, cost and so forth. It's not meant to say total cost of ownership for this product versus this product ... versus ... . What we talk about is addressing provider concerns that they thought they bought a complete EHR that the vendor then says to them, oh, if you want to get this public health reporting module that is necessary for you to attain meaningful use that will be another $10,000. So it's ... quite specifically about price transparency regarding what you're buying. If you have a certification number which is almost the –

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Yes, which is not what we talked about, yes.

Farzad Mostashari – Office of the National Coordinator– National Coordinator for Health Information Technology

... are part of that certification number and the price appertains to that certification number.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

We missed that, if that was the –

W

But don't all the concerns still hold?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

The recommendation that we include this in the final rule, we were thinking something very different about pricing.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yours almost sounds like truth in advertising.

W

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Versus pricing percent.

W

That's how you differentiate between the price for all the modules that are necessary for meaningful use versus the price of all the modules.

W

No, but I think the point is what are you selling, how much is it, and what does it include, right?

W

Okay, so for –

W

Yes.

W

... a vendor how many ORs are there, how many lab test results, how many pharmacy orders, how do you put that all together? And then, do you have to re-buy every certain number of years? There are so many components that go to it.

W

So let me just say quickly that I could not agree to oppose the pricing transparency that Farzad just explained in the rule, because I think it's important to include it.

W

I think it's practically impossible. But you have to give the parameters of the single doc, is it 100, is it a hospital, what is it? And then what are all the parameters of that organization? I think it's far away from being very clear.

W

Yes, and I'm not trying to be insensitive to that, but I don't think I could, in the few minutes we have left, be on board with saying that that should come out.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So it's clear that there's meaty issues in here on that page, and these are new so we're going to have to make some time to discuss this between now and the end of the week. If you want to point out some things where we should go back and think about it, that's probably helpful for us to pre-think about them. One was this, pricing was another, or are they all in this category?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

I think that the problem is that the Info button was one where we went round and round and round about exactly what was being asked for our Info button, so if we had that much confusion was it just us or was it not clear in the proposed rule? The simple answer is the Info button is just one way to deliver information, and if you're using it then you should use the standard, so I could interpret it very narrow.

Christine Bechtel – National Partnership for Women & Families – VP

But I think, Larry, part of my question, and I know we're trying to stop this, ... how –

M

You were trying to stop this.

Christine Bechtel – National Partnership for Women & Families – VP

I was. ... .

M

..., Christine.

Christine Bechtel – National Partnership for Women & Families – VP

I did ... Standards Committee recommendation, so I think a phone call's a good idea. Paul, don't you think?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, let's do a phone call now. And what we'll do, speaking of the Standards Committee, is try to invite the chairs to weigh in on this and potentially clarify some of the things. Okay, so the challenge and the charge is to find the time, I think we ought to limit ourselves to an hour anyway, just because that's what we were allotted for –

M

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

... and we'll have to do this between now and the end of the week. Any other last minute things before we go to public comment?

M

Paul, can I ask just a process question. We had a couple of things that were deferred to the Standards Committee. What's the process for that? Are the recommendations going to be sent to the Standards Committee, the IE Workgroup recommendations?

Farzad Mostashari – Office of the National Coordinator– National Coordinator for Health Information Technology

Yes, the ... plays an important one. They also had some issues where they said, like medication allergies and non-medication allergies, where they punted it back to you guys and said RxNorm now includes some food allergy information as well, what does the Health IT Policy Committee want to do with that. So I think there are a few items where we need to tighten that interplay, and Mary Jo has an idea about how to do that.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

No, I actually don't have an idea, but I have several process thoughts that I wanted to put on the table ... where we're sort of huddling, and I'm not sure I'm going to necessarily speak for a consensus this morning in terms of questions. Question number one is you do still have a quorum, have you made a decision, you do not wish to go beyond 3:00, is that a hard and fast rule?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

A lot of us have planes. I have a plane.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

Okay, that's a hard and fast decision. Point number two that we're debating here is that these are comments on a rule, they're not formal recommendations, so there are different ways to accommodate that. I'm not sure we have the exact answer as to what those ways are, but I would point out that that means that you have latitude in what you are doing, not least of which is any comments can be submitted by any entity as long as it's not in the name of the Policy Committee through Regulations.gov and be put forward.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And the integration can be done by us.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

Right. And then to the third point that you were just raising about the interplay, because I know that in the document that Steve just is sending out right now, there's a separate section that's supposedly ... back to the Policy Committee and we don't have time before the end of the comment period for you all to address each other's asks in those respects. That's just logistically not going to be possible. I think it would be a matter of noting that they've been thrown back and having to deal with them outside of what you say back through the comments period.

Farzad Mostashari – Office of the National Coordinator– National Coordinator for Health Information Technology

I think that at a minimum what we can do is we do need, and we discussed, another phone call on the certification piece. I think it makes sense to invite the chairs potentially and potentially the Certification Workgroup and Implementation Workgroup of the Standards Committee on that call and we can try to get done as much as we can get done on that to clarify the issues and to get to the point where we have a comment. And other issues will have to be resolved post-comment.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

And ONC, since the certification adoption comments are on the ONC rule, you're certainly always free to submit comments to us and it's a question of our sense of timing or not of whether we feel we are able to address them. CMS, as I understand it, has a much more stringent deadline on what it receives with regard to its NPRM.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Will they allow us to go to June?

W

That would be characterizing them, wouldn't it, Mary Jo, as recommendations and our normal course of work of recommendations of recommending things to ONC versus submitting official comments as part of a regulatory timeline?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So we'll try to meet the same timeline, we're not bound to it, but they have a timeline as well so we're just trying to meet their timeline. And I guess one question is, does your timeline allow us to deliberate these particular issues –

Farzad Mostashari – Office of the National Coordinator– National Coordinator for Health Information Technology

I'm looking at the lawyer here. But I think that it would be more comfortable for us, and we certainly could make reference in a final rule to comments but not to information that came in outside of the comment period. We're quite clear on that. So if we can get it into the comments by May 7th, I think it's much more comfortable in terms of making sure that we can use it in our final rule making. Let's do that. I think it's most comfortable and it's been the style we've been operating under to have a committee comment go in, so let's do try to do that, let's try to get a call, and I'm guessing it's an hour and a half between now and the end of the week, so that we can include it in our formal comments back to ONC.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

If I'm hearing you correctly that call would have to be tomorrow, because you –

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

What's today?

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

Today's Wednesday, and so the call would have to happen on Thursday, so we need to check with you before you leave today on your availability. Then the issue will be you may not be able to get a quorum on a call called with virtually 24 hours notice.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so how does the group feel about including comments as part of our response to the NPRM that does not include a quorum for this particular part of it?

Farzad Mostashari – Office of the National Coordinator– National Coordinator for Health Information Technology

It would be comments submitted by the Certification Adoption Workgroup then?

W

Right, they would be characterizing the results of their ... .

W

... a formal process. I don't believe you can make a comment from this group.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

The Policy Committee?

W

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

That's fine. Okay.

W

I'd be comfortable with that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, we'll try to get a quorum if we can, and then otherwise we'll ... this from the Certification Adoption Workgroup, or whatever it is.

M

Sorry, I don't want to belabor this, but what about the ones that were deferred to the Standards Committee?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

The HL7, was that covered by standards, by any chance?

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

Is that the one that –

M

There were two workgroup requirements, two workgroup recommendations or comments the way the ... and grandfathering 2.3.1 in special cases.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

Were those made in your recent submission ... . Those have not been formally transmitted then, because they have no means of actively considering them in the time available either.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Unfortunately your views have been heard, and it's possible they could, and I'm not being facetious, it's possible they certainly could influence the views of the people listening and considering all of the possible options.

M

Weren't you going to send the long version from each workgroup as an appendix? The recommendations you've voted on, you had talked about sending it as an appendix. Is that –

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

What we said is that they would be on the public record because –

M

Okay, sorry.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

... submitted through this. So they're in the public record and they are available, but they're not submitted through the comment process unless –

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So there are multiple avenues for comments on the NPRM. There's all this public deliberation and it doesn't fall on deaf ears. There's a formal HIT PC endorsed set of comments. There are comments from individuals. There are comments from the organization, so there's plenty of ways to get the information heard. There's only one way to get an HIT PC approved comment in, and we're trying to go through that.

We got cut off by time in terms of some of these.

W

Maybe tomorrow morning we can find some time.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

That's right.

W

Early morning California.

W

Early morning ... .

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

No that would be 3:00 a.m.

M

It won't be the first ... call you've been on, Paul.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Thank you all for your forbearance, both in going through all of this. I think you did a great job. We missed off a little bit, but that was probably going to happen. And thanks for all your tremendous thoughts about that. I think we have a public comment .... . Please, public comments.

Public Comment

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

Operator, would you open the lines for public comment, please?

Operator

(Instructions given.) We have no comments at this time.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Thank you very much, and I'll see you next month at –

M

Are there any comments in the room? Yes?

Kellan Baker – LGBT Research and Communications Project at the Center for American Progress – Health Policy Analyst

I know everyone ... out of here, trust me, I feel all your pain so I will keep this very, very short. Good afternoon, my name is Kellan Baker. I'm a Health Policy Analyst with the LGBT Research and Communications Project at the Center for American Progress here in D.C. I just wanted to thank the workgroup for all of the work that you've been doing. I know you've been working very hard locked in this room for many hours. I wanted to just make a quick comment in support of a discussion I know has been happening around the table, which is the question of the inclusion of data on sexual orientation and gender identity on the health of lesbian, gay, bisexual, and transgender patients. The reasons for including these steps are many, I won't keep you here with a long run down of them, suffice to say that the LGBT community population experiences significant health disparities, as testified to by sources such as Healthy People 2020, which has a new LGBT health topic area, the Institute of Medicine, LGBT Health Report from 2011, and the current activities at the Department of Health and Human Services regarding collecting better data, particularly starting with national health surveys on the health of the LGBT population. The reasons for doing this in a clinical setting, obviously prevention, quality, and tracking some of these population level disparities, as well as building a closer relationship between a patient and the provider.

We're working on ways of figuring out how best to do this. We're actually setting up a workshop with the Institute of Medicine for later this year that will bring together stakeholders in this field to determine what are some of the challenges, what are some of the best ways to do this, and what do we need in order to support providers and patients going forward in collecting these kinds of data. We are submitting comments for the CMS NPRM, which included a specific request for information on the benefits of collecting these data, but I just wanted to support the discussions that you all are having around this particular topic, and to emphasize that we recommend that CMS and ONC commit to collecting these data in Stage 3. I know there's been a lot of discussion about Stage 2 versus Stage 3, but in order to make sure that we are well prepared to do this and that providers and patients are supported in making sure these data are collected appropriately and go to good ends, again, we recommend that these data be collected in Stage 3, and that Stage 2 do what it can in terms of policy language to prepare the road for that. Thank you again. Have a good afternoon.

Public Comment Received During the Meeting

1. Is there any background on why Transition of Care Summary not popular? We have comment from our hospital customers that may assist as to why.